No.

In the Supreme Court of the United States

ALEX M. AZAR II, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

ALLINA HEALTH SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

APPENDIX TO THE PETITION FOR A WRIT OF CERTIORARI

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 16-5255

ALLINA HEALTH SERVICES, DOING BUSINESS AS UNITED HOSPITAL, DOING BUSINESS AS UNITY HOSPITAL, DOING BUSINESS AS ABBOTT NORTHWESTERN HOSPITAL, ET AL., APPELLANTS

v.

THOMAS E. PRICE, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, APPELLEE

Argued: May 11, 2017
Decided: July 25, 2017

Appeal from the United States District Court for the District of Columbia (No. 1:14-cv-01415)

Before: HENDERSON, KAVANAUGH, and MILLETT, *Circuit Judges.*

Opinion for the Court filed by *Circuit Judge* KAVANAUGH.

KAVANAUGH, *Circuit Judge*: Several hospitals have challenged the formula used by the Department of Health and Human Services for calculating certain Medicare reimbursement adjustments for fiscal year 2012. As relevant here, the hospitals argued before the District

Court that HHS violated the Medicare Act by changing the reimbursement adjustment formula without providing the public with notice and opportunity for comment.

The District Court ruled that HHS did not violate the Medicare Act's procedural requirements. The District Court reasoned that (i) the Medicare Act incorporates the Administrative Procedure Act's exception to notice-and-comment rulemaking for interpretive rules and (ii) HHS's issuance of the reimbursement adjustment formula here constituted an interpretive rule. The District Court granted summary judgment to HHS.

We disagree with the District Court. We conclude that HHS violated the Medicare Act when it changed its reimbursement adjustment formula without providing notice and opportunity for comment. We reverse the judgment of the District Court and remand for proceedings consistent with this opinion.

I

A

Through the Medicare program, the Federal Government provides health insurance to Americans who are 65 or older, as well as to disabled Americans. *See generally* Social Security Amendments of 1965, Pub. L. No. 89-97, sec. 102, 79 Stat. 286, 291-332 (codified as amended at 42 U.S.C. § 1395 *et seq.*). The Department of Health and Human Services administers and oversees Medicare. Patients can obtain insurance under different Medicare "parts." Two of those parts are relevant here. Medicare Part A provides Medicare enrollees with government-administered health insurance through which the Government makes direct payments to hospitals for healthcare services provided. *See*

42 U.S.C. §§ 1395c to 1395i-5. Part C provides enrollees with government-subsidized enrollment in private insurance plans. *See id.* §§ 1395w-21 to 1395w-29.

HHS contracts with companies known as fiscal intermediaries to reimburse healthcare service providers for services rendered to Medicare Part A patients. Fiscal intermediaries make initial payments to hospitals for a given cost year. Those initial payments are based on estimates of the hospitals' actual costs. The initial payments are later adjusted based on providers' actual cost reports.

A provider who disagrees with a fiscal intermediary's reimbursement or adjustment decision may appeal that decision to the Provider Reimbursement Review Board within HHS. *See* 42 U.S.C. § 1395*oo*. The Board may affirm, modify, or reverse the fiscal intermediary's decision. *Id.* § 1395*oo*(d). But importantly, the Board does not have the authority to declare statutes or regulations invalid. *See Bethesda Hospital Association v. Bowen*, 485 U.S. 399, 406 (1988); 42 C.F.R. § 405.1842(f)(2)(ii).

As relevant here, the Medicare Act authorizes reimbursement adjustments in order to increase payments to hospitals that treat a disproportionately high number of low-income patients. *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). That adjustment is known as the "disproportionate share hospital adjustment." The adjustment is calculated for each hospital by adding two fractions that together approximate the proportion of low-income patients treated at that hospital over a certain time period. *See id.* § 1395ww(d)(5)(F)(vi). HHS calculates and publishes one of those fractions—the Medicare fraction—for each hospital in the Nation every year. HHS requires the fiscal intermediaries to

use HHS's published Medicare fractions in calculating each hospital's final reimbursement adjustment. *See* 42 C.F.R. § 412.106(b)(2), (5).

Among other things, the Medicare fraction incorporates the number of each hospital's patient days for patients "entitled to benefits under part A" of Medicare. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The meaning of that phrase has been the subject of much debate (and litigation). The dispute is over whether the phrase "entitled to benefits under Part A" should be read to refer not only to Part A enrollees, but also to patients enrolled in a Part C plan.

For reasons that are beyond the scope of this opinion, HHS now believes that the phrase "entitled to benefits under Part A" should also include patients enrolled in a Part C plan. HHS therefore contends that Part C patient days should be included in the Medicare fractions. Many hospitals disagree. They argue that Part C enrollees are *not* "entitled to benefits under Part A" and that Part C days therefore should *not* be included in Medicare fractions.

That difference in interpretation makes a huge difference in the real world. Part C enrollees tend to be wealthier than Part A enrollees. Including Part C days in Medicare fractions therefore tends to lead to lower reimbursement rates. Ultimately, hundreds of millions of dollars are at stake for the Government and the hospitals. *See Northeast Hospital Corp. v. Sebelius*, 657 F.3d 1, 5 (D.C. Cir. 2011).

Before 2004, HHS had *not* treated Part C enrollees as "entitled to benefits under Part A." *See id.* at 15. In 2004, however, HHS promulgated a rule announcing

that Part C enrollees *are* "entitled to benefits under Part A" and that HHS would therefore include Part C days in Medicare fractions. *See* Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, 69 Fed. Reg. 48,916, 49,099 (Aug. 11, 2004). That 2004 rule would have applied HHS's changed interpretation prospectively to all Medicare fraction calculations from fiscal year 2005 onward. However, this Court vacated the 2004 rule on the grounds that it was not a logical outgrowth of the proposed rule and had therefore been improperly issued without notice and opportunity for comment. *See Allina Health Services v. Sebelius*, 746 F.3d 1102, 1107-09 (D.C. Cir. 2014). As a result, HHS can no longer rely on the 2004 interpretation.

In 2013, HHS promulgated a new rule again announcing that HHS would treat Part C enrollees as "entitled to benefits under Part A" and that HHS would therefore include Part C days in Medicare fractions. *See* 78 Fed. Reg. 50,496, 50,614 (Aug. 19, 2013). The 2013 rule is prospective only: It applies to Medicare fractions calculated for fiscal year 2014 and beyond. *Id.* at 50,619. It does not address the definition of "entitled to benefits under Part A" for any fiscal years before 2014. In sum, HHS has no promulgated rule governing the interpretation of "entitled to benefits under Part A" for the fiscal years before 2014.

B

In June 2014, HHS published the Medicare fractions to be used in calculating disproportionate share hospital adjustments for fiscal year 2012. At the top of the spreadsheet containing those fractions, HHS noted that it had included Part C days in the Medicare fractions.

The spreadsheet contained the 2012 Medicare fractions for all hospitals nationwide.

Plaintiffs in this case are hospitals that provide health care to low-income Medicare patients and that are therefore entitled to disproportionate share hospital adjustments. Those hospitals here challenge HHS's June 2014 decision to include Part C days in the 2012 Medicare fractions.

As required by statute, the hospitals first sought review by the Provider Reimbursement Review Board within HHS. But the hospitals believed that the Board did not have the authority to resolve the hospitals' challenges because the hospitals' challenges related to the validity of several HHS regulations. Under HHS's rules implementing the Medicare statute, the Board may not review challenges "either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation." 42 C.F.R. § 405.1842(f)(1). The hospitals therefore sought expedited judicial review, which is available under the statute when the Board certifies that it does not have authority to resolve a provider's challenge. When the Board so certifies, the provider may bring suit in district court without proceeding through the full Board review process. *See* 42 U.S.C. § 1395*oo*(f)(1).

Here, the Board agreed with the hospitals that it did not have the authority to resolve the hospitals' challenge. That no-authority determination allowed the hospitals to promptly bring suit in District Court challenging HHS's decision to include Part C days in the Medicare fractions for fiscal year 2012.

In the District Court, HHS moved to dismiss the hospitals' case on the ground that the case was premature. HHS argued that the Board's no-authority determination was erroneous, and that the District Court therefore did not have authority to consider the challenges to the Medicare fractions until the Board ruled on that claim. The hospitals responded that the Board's no-authority determination was not reviewable by the District Court and that, in any event, the Board's no-authority determination was correct. The District Court agreed with HHS that the District Court could review the Board's no-authority determination. The District Court agreed with the hospitals, however, that the Board's no-authority determination was correct. The District Court therefore denied HHS's motion to dismiss.

Both sides then moved for summary judgment on the merits of the hospitals' challenges. The hospitals contended that HHS violated the Administrative Procedure Act and the Medicare Act by including Part C days in the fiscal year 2012 Medicare fractions without first providing the public with notice and opportunity for comment. They also argued that the calculations were arbitrary and capricious. HHS responded that its decision was procedurally and substantively proper.

The District Court granted summary judgment to HHS. First, the District Court held that the June 2014 decision to include Part C days in the 2012 Medicare fractions was an "interpretive rule" under the APA. As a result, the District Court concluded that HHS's publication of the fiscal year 2012 Medicare fractions was statutorily exempt from the APA's notice-and-comment requirements. Second, the District Court held that the Medicare Act incorporated the APA's notice-and-

comment exception for interpretive rules. The District Court therefore held that HHS had not violated the Medicare Act's procedural requirements. Third, the District Court held that HHS's decision to include Part C days in the 2012 Medicare fractions was not arbitrary and capricious.

The hospitals now appeal the District Court's grant of summary judgment to HHS. This Court reviews a district court's grant of summary judgment de novo. *See Southeast Alabama Medical Center v. Sebelius*, 572 F.3d 912, 916 (D.C. Cir. 2009).

II

HHS's Provider Reimbursement Review Board concluded that it lacked authority to decide this dispute. The Board therefore certified the case for expedited judicial review in the District Court. The District Court concluded that it had authority to decide the case. We must first consider whether the District Court correctly concluded that it had authority to decide the case now, or whether the dispute instead should have been decided first by HHS's Provider Reimbursement Review Board.

HHS argues that the dispute should have been decided first by the Board. The hospitals raise two alternative points in response. They contend that the District Court may not review the Board's no-authority determination. The hospitals also argue in the alternative that even if the District Court may review the Board's no-authority determination, the Board here was correct to conclude that it did not have authority to hear the hospitals' challenge. We agree with the hospitals on both alternative arguments.

To begin, the hospitals are correct that a district court may not review the Board's no-authority determination at HHS's request. The Medicare Act states that providers—and only providers—"*shall*" have "the right to obtain" expedited judicial review "*whenever* the *Board* determines . . . that it is without authority to decide" a particular question. 42 U.S.C. § 1395*oo*(f)(1) (emphasis added).[1] In other words, providers are guaranteed expedited judicial review when the Board makes a no-authority determination, as the Board did here. The statute conditions expedited judicial review in the district court on the existence of that no-authority determination, *not* on whether that determination is correct.

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[1] As relevant here, the statutory provision for expedited judicial review reads: "Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing." 42 U.S.C. § 1395*oo*(f)(1).

The statutory structure confirms that reading of the text. A provider may bring suit in the district court even when the Board fails to make a timely determination of its authority to decide a case. *See id.* ("If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing."). As the hospitals rightly point out, it would be "nonsensical if judicial review could be defeated by disagreement with the Board's no-authority decision, even though the Board's failure to make such a decision undisputedly confers federal court jurisdiction." Allina Reply Br. 5.

Put simply, Congress has allowed providers to seek immediate judicial review when the Board concludes that an extensive and time-consuming administrative process before the Board would likely be pointless. Requiring parties in district court to fully brief and re-litigate the Board's assessment of its own lack of authority—a question that may often be inextricably linked to the merits of a provider's challenge—runs entirely counter to that statutory scheme.[2]

In any event, even if we were wrong about that point, the Board here was correct in deciding that it did not have authority to resolve the hospitals' challenge. Under HHS regulations implementing the statute's expedited judicial review procedure, the Board "must grant" expedited judicial review if the legal question

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[2] We recognize that our decision here breaks with other courts of appeals that have concluded that the Board's no-authority determinations are reviewable. *See, e.g., Providence Yakima Medical Center v. Sebelius*, 611 F.3d 1181, 1187 n.7 (9th Cir. 2010).

raised "is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation." 42 C.F.R. § 405.1842(f)(1). The hospitals here pressed two arguments before the Board. Both arguments challenged the "substantive or procedural validity" of different regulations. *Id.* § 405.1842(f)(1)(ii). First, the hospitals argued that HHS erred when it chose to apply the formula from the vacated 2004 rule in calculating the 2012 fractions. The hospitals' first argument therefore raised the question of the 2004 rule's continuing legal validity. Second, the hospitals argued that HHS violated various procedural requirements by promulgating a new regulation without notice-and-comment rulemaking. That argument turned on whether the decision to include Part C days in the 2012 Medicare fractions constituted a new regulation, and if it did, whether that new regulation was procedurally valid. Both of the hospitals' arguments raise legal questions about the "substantive or procedural validity of a regulation." *Id.* The Board's no-authority determination was correct. The District Court correctly concluded that it had authority to decide the case now.

III

A

We turn therefore to the hospitals' claim that HHS violated the Medicare Act by failing to provide for notice and comment before including Part C days in the 2012 Medicare fractions. We agree with the hospitals that HHS unlawfully failed to provide for notice and comment.

The Medicare Act describes in fairly straightforward language when notice and comment is necessary. Paragraph (2) of Section 1395hh(a) provides:

> No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

42 U.S.C. § 1395hh(a)(2). Paragraph (1), in turn, requires the HHS Secretary to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs" under the Medicare Act. *Id.* § 1395hh(a)(1). With a few exceptions not relevant here, "the Secretary shall provide for notice of the proposed regulation" to allow "for public comment thereon." *Id.* § 1395hh(b)(1).

In other words, as relevant here, the Medicare Act requires notice-and-comment rulemaking for any (1) "rule, requirement, or other statement of policy" that (2) "establishes or changes" (3) a "substantive legal standard" that (4) governs "payment for services." *Id.* § 1395hh(a)(2). All four requirements are readily met here.

First, HHS's inclusion of Part C days in the fiscal year 2012 Medicare fractions is, at the very least, a "requirement." Fiscal intermediaries are *commanded* to use HHS's Medicare fractions in calculating adjustment amounts. *See* 42 C.F.R. § 412.106(b)(2), (5).

Those fractions treat Part C enrollees as "entitled to benefits under Part A." The fiscal intermediaries are therefore *required* to include Part C days in their calculations as they determine reimbursement adjustments. In short, HHS promulgated a "requirement" when it announced that the 2012 Medicare fractions would include Part C days.

Second, HHS's inclusion of Part C days in the fiscal year 2012 Medicare fractions represents a change in HHS's standards. Before 2004, HHS's standard practice was to *exclude* Part C days from Medicare fractions. *See Northeast Hospital Corp. v. Sebelius*, 657 F.3d 1, 15 (D.C. Cir. 2011). HHS's 2004 rule attempted to change that standard so that the Medicare fractions would *include* Part C days. *Id.* at 14. But that rule was vacated. *See Allina Health Services v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014) (*Allina I*). Although HHS promulgated a new rule in 2013 that includes Part C days in Medicare fractions, that rule applies only prospectively to reimbursement adjustments for fiscal years 2014 and beyond.[3] As a result, the pre-2004 standard of excluding Part C days from Medicare fractions remains the baseline practice from which this Court must evaluate any decisions for 2012. The decision to include Part C days in the 2012 Medicare fractions is therefore a change from prior practice.

Third, HHS's inclusion of Part C days in the fiscal year 2012 Medicare fractions establishes a "substantive legal standard." "Substantive law" is law that "creates, defines, and regulates the rights, duties, and powers of

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[3] The 2013 rule is the subject of pending litigation in the District Court. We express no views on the merits of that case.

parties." BLACK'S LAW DICTIONARY (10th ed. 2014). A "substantive legal standard" at a minimum includes a standard that "creates, defines, and regulates the rights, duties, and powers of parties." That is precisely what HHS's 2012 Medicare fractions do. The fiscal intermediaries must use HHS's published Medicare fractions in determining how much the hospitals will be reimbursed. HHS's fractions therefore define the scope of hospitals' legal rights to payment for treating low-income patients.

Fourth, HHS's inclusion of Part C days in the fiscal year 2012 Medicare fractions governs "payment for services." The fractions are used to calculate the payment that providers will receive for providing healthcare services to low-income patients. The inclusion of Part C days means that the providers will now receive lower payments.

In sum, HHS's decision to include Part C days in the 2012 Medicare fractions is covered by the text of Section 1395hh(a)(2). The Medicare Act therefore required HHS to engage in notice-and-comment rulemaking before deciding to include Part C days in the 2012 Medicare fractions. Because HHS did not undertake notice-and-comment rulemaking, the 2012 Medicare fractions are procedurally invalid.

B

HHS's arguments to the contrary are not persuasive.

First, HHS argues that the fractions are not a "rule, requirement, or statement of policy" because the fractions apply only to the parties in this particular case for the year 2012. That argument is factually inaccurate. HHS published Medicare fractions for *every hospital in the country*. All of those fractions include Part C

days. Indeed, during oral argument, HHS forthrightly acknowledged that it would "generally" maintain a "consistent interpretation" for all hospitals for a given year, meaning that the policy applied to the hospitals in this case would apply to all hospitals nationwide. Tr. of Oral Arg. at 29:20-21. Moreover, as the hospitals point out, the 2012 Medicare fractions will be the basis not just for 2012 adjustments, but also for interim 2013 payments until HHS publishes the 2013 fractions. *See* 42 C.F.R. § 413.64(e). In other words, the decision to include Part C days in the 2012 Medicare fractions affects more hospitals than just the parties in this particular case for this particular year.

Second, HHS argues that the Medicare Act incorporates the APA's exceptions to notice-and-comment requirements. According to HHS, even if the decision to include Part C days in the fiscal year 2012 Medicare fractions is a rule, it is at most an "interpretive rule" for purposes of the APA. As a result, it is exempt from the APA's—and, by extension, the Medicare Act's —notice-and-comment requirements.

The problem with that argument is that the Medicare Act does not incorporate the APA's interpretive-rule exception to the notice-and-comment requirement. (Therefore, we need not decide whether HHS's decision to include Part C days in the 2012 Medicare fractions was in fact an interpretive rule.)

Unlike the APA, the text of the Medicare Act does not exempt interpretive rules from notice-and-comment rulemaking. On the contrary, the text expressly *requires* notice-and-comment rulemaking. The Medicare Act states: "*No* rule, requirement, or other statement of policy . . . shall take effect *unless* it is promulgated"

through notice-and-comment rulemaking. 42 U.S.C. § 1395hh(a)(2) (emphasis added); *id.* § 1395hh(b)(1). The provision does not include an exception for interpretive rules. By contrast, the APA requires notice and comment only for "proposed rule making" and exempts "interpretative rules, general statements of policy, [and] rules of agency organization, procedure, or practice" from notice-and-comment requirements. 5 U.S.C. § 553(b). We must respect Congress's use of different language and its establishment of different notice-and-comment requirements in the Medicare Act and the APA. *Cf.* WILLIAM N. ESKRIDGE JR., INTERPRETING LAW: A PRIMER ON HOW TO READ STATUTES AND THE CONSTITUTION 109-10 (2016) ("Where a statute repeatedly uses one term or phrase, one expects that a materially different phraseology demands a different reading."); ANTONIN SCALIA & BRYAN A. GARNER, READING LAW: THE INTERPRETATION OF LEGAL TEXTS 170 (2012) ("[A] material variation in terms suggests a variation in meaning.").

Moreover, Congress knew how to incorporate the APA's notice-and-comment exceptions into the Medicare Act when it wanted to. After all, the Medicare Act expressly incorporates other APA notice-and-comment exceptions. Specifically, the Medicare Act incorporates the APA's "good cause" exception. *See* 42 U.S.C. § 1395hh(b)(2) (Notice-and-comment rulemaking requirement "shall not apply where— . . . subsection (b) of section 553 of title 5 does not apply pursuant to subparagraph (B) of such subsection."). But in the Medicare Act, Congress did not incorporate the APA's interpretive-rule exception to notice-and-comment requirements.

We recognize that we are breaking with several other courts of appeals by holding that the Medicare Act does not incorporate all of the APA's exceptions to the notice-and-comment requirement. *See, e.g., Via Christi Regional Medical Center, Inc. v. Leavitt*, 509 F.3d 1259, 1271 n.11 (10th Cir. 2007); *Baptist Health v. Thompson*, 458 F.3d 768, 776 n.9 (8th Cir. 2006); *Omni Manor Nursing Home v. Thompson*, 151 Fed. App'x 427, 431 (6th Cir. 2005); *Warder v. Shalala*, 149 F.3d 73, 79 n.4 (1st Cir. 1998).[4] But we respectfully disagree with those opinions. As discussed, we conclude that the Medicare Act does not incorporate the APA's interpretive-rule exception to the notice-and-comment requirement.

C

Finally, even if HHS were correct that the Medicare Act somehow incorporated the APA's notice-and-comment exception for interpretive rules, HHS would still not prevail here. That is because another provision of the Medicare Act, Section 1395hh(a)(4), expressly required notice and comment in this case. Section 1395hh(a)(4) reads in full:

> If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect

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[4] As HHS points out, this Court's prior decision in *Monmouth Medical Center v. Thompson*, 257 F.3d 807, 814 n.2 (D.C. Cir. 2001), noted the question of whether the Medicare Act incorporates the APA's interpretive-rule exception. But as HHS recognizes, *Monmouth* did not "expressly decide the question" raised here. HHS Br. 44.

> until there is the further opportunity for public comment and a publication of the provision again as a final regulation.

42 U.S.C. § 1395hh(a)(4). In other words, if a regulation includes a "provision that is not a logical outgrowth of a previously published notice of proposed rulemaking," that provision may not become legally operative until it has gone through notice-and-comment rulemaking. *Id.*

Section 1395hh(a)(4) applies with full force here. This Court vacated HHS's 2004 rule treating Part C enrollees as "entitled to benefits under Part A" because the 2004 rule "was not a logical outgrowth of the proposed rule." *Allina I*, 746 F.3d at 1109. HHS therefore had to provide a "further opportunity for public comment and a publication of the provision again as a final regulation" before HHS could re-impose the rule. 42 U.S.C. § 1395hh(a)(4). HHS did not do so. And HHS could not circumvent this requirement by claiming that it was acting by way of adjudication rather than rulemaking. The statutory text says that the vacated rule may not "take effect" at all until there has been notice and comment.

* * *

Because we conclude that HHS has failed to provide notice and comment as required by the Medicare Act, we need not consider whether HHS's decision was arbitrary and capricious. We reverse the judgment of the District Court and remand for proceedings consistent with this opinion.

So ordered.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 14-1415 (GK)

ALLINA HEALTH SERVICES, ET AL., PLAINTIFFS

v.

SYLVIA M. BURWELL, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEFENDANT

[Filed: Aug. 17, 2016]

MEMORANDUM OPINION

Plaintiffs Allina Health Services, et al. ("Plaintiffs") are nine hospitals that bring this action against Sylvia M. Burwell, in her official capacity as Secretary of the United States Department of Health and Human Services ("Secretary" or "Defendant"). They challenge the calculation of certain disproportionate share hospital payments as procedurally and substantively invalid.

This matter is before the Court on the Plaintiff's Motion for Summary Judgment [Dkt. No. 8] and Defendant's Cross-Motion for Summary Judgment [Dkt. No. 28]. Upon consideration of the Motions, Oppositions, Replies, the entire record herein, and for the reasons set forth below, Plaintiffs' Motion shall be **denied** and Defendant's Motion shall be **granted.**

I. Background

A. The Medicare DSH Payment System

The Medicare program was established in 1965 and provides health care coverage for persons age 65 and older, disabled persons, and persons with end stage renal disease who meet certain eligibility requirements. See 42 U.S.C. § 426, 426a. The Secretary administers the program through the Centers for Medicare & Medicaid Services (CMS), an agency with the United States Department of Health and Human Services. Def.'s Mot. at 4.

Medicare pays benefits through different plans, three of which are relevant here. "Plan A covers medical services furnished by hospitals and other institutional care providers." Ne. Hosp. Corp. v. Sebelius, 657 F.3d 1, 2 (D.C. Cir. 2011); 42 U.S.C. §§ 1395c to 1395i-5. "Part B is an optional supplemental insurance program that pays for medical items and services not covered by Part A, including outpatient physician services, clinical laboratory tests, and durable medical equipment." Ne. Hosp., 657 F.3d at 2; 42 U.S.C. §§ 1395j to 1395w-4. "Part C governs the 'Medicare + Choice' (M+C) program, which gives Medicare beneficiaries an alternative to the traditional Part A fee-for-service system," allowing enrollment in a managed care plan. Ne. Hosp., 657 F.3d at 2; see 42 U.S.C. §§ 1395w-21 to 1395w-29. The Secretary pays the health care provider directly under Parts A and B, but pays the managed-care plan under Part C, which in turn pays the provider.

Hospitals that serve a significantly disproportionate share of low-income patients without private health insurance are paid "additional monies [by Medicare], on

top of Medicare's normal fees-for-service, to help cover the costs associated with the care of the very poor." Allina Health Servs. v. Sebelius, 904 F. Supp. 2d 75, 77 (D.D.C. 2012) ("Allina I"); see also 42 U.S.C. § 1395ww(d)(5)(F); 42 C.F.R. § 412.106.

The disproportionate share hospital ("DSH") adjustment is based on a "disproportionate patient percentage" for each hospital, which is determined by a complicated statutory formula. See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d). The disproportionate patient percentage is the sum of two fractions, 42 U.S.C. § 1395ww(d)(5)(F)(vi), which are commonly known as the "Medicaid fraction" and the "Medicare fraction" (sometimes also referred to as the "SSI fraction").

The Medicare fraction is defined as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of [Title XVIII] and were entitled to supplemental security income benefits (excluding any State supplementation) under [Title] XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of [Title XVIII] . . .

42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (emphasis added). In layman's terms, the top of the Medicare fraction is based on the number of a hospital's patient days for individuals entitled to both Medicare Part A and SSI benefits, and the bottom of the fraction is based on the

number of patient days for all patients under Part A. As discussed later, the phrase "entitled to benefits under part A" is key to the present dispute.

The Medicaid fraction is defined as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State [Medicaid] plan . . . but who were not entitled to benefits under [Medicare] Part A . . . and the denominator of which is the total number of the hospital's patient days for such period.

Id. § 1395ww(d)(5)(F)(vi)(II). In layman's terms, the top of the Medicaid fraction is based on the number of a hospital's patient days for individuals who are eligible for Medicaid, but who are not entitled to benefits under Medicare Part A, and the bottom is the total number of all patient days for the hospital. For a visual representation of the fractions, see Ne. Hosp., 657 F.3d 1, 3.

M+C (also referred to as Part C) was established by Congress in 1997 as part of the Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33 (1997). In order to enroll in M+C, an individual must be "entitled to benefits under part A . . . and enrolled under part B." 42 U.S.C. § 1395w-21(a)(3)(A). After M+C was implemented, "the Secretary routinely excluded M+C [inpatient hospital] days from the Medicare fraction" from 1999 to 2004. Ne. Hosp., 657 F.3d at 15. That is, M+C patients were not counted in the numerator of the Medicare fraction as part of the patients "entitled to benefits under Part A . . . and entitled to [SSI] benefits." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). It was

not until 2007 that the Secretary began to collect the data needed to include M+C days in the Medicare/SSI fraction. Id.; see Change Request 5647, CMS Pub. 100-04, Transmittal No. 1331 (July 20, 2007).

Central to this case is whether, once enrolled in Part C, enrollees continue to be entitled to benefits under Part A. If the agency considers enrollees to be entitled to benefits under Part A, then they should be included in the Medicare fraction. If they are no longer entitled to benefits under Part A, because they are receiving benefits under Part C, then they should be excluded from the Medicare fraction. The financial impact on the hospitals of this seemingly minor detail is in the hundreds of millions of dollars. See Allina Health Servs. v. Sebelius, 746 F.3d 1102, 1105 (D.C. Cir. 2014) ("Allina I Appeal").

B. Factual Background

In Allina I, a group of hospitals, including the Plaintiffs in the present case, challenged a 2004 rulemaking by the Secretary ("2004 Final Rule"). See 904 F. Supp. 2d at 77. The 2004 rulemaking adopted a policy whereby Part C patients were to be considered as "entitled to benefits under part A," and therefore counted in the numerator of the Medicare fraction. In November 2012, the Court (Collyer, J.) granted summary judgment for the plaintiffs, finding that the 2004 Final Rule was not a logical outgrowth of the proposed rule and therefore violated the procedural requirements of the Administrative Procedure Act ("APA"). See Allina I, 904 F. Supp. 2d at 89-90.

On appeal, our Court of Appeals affirmed the part of the Allina I Court's decision vacating the 2004 Final

Rule. But, the Court of Appeals held that the Allina I Court erred when it directed the Secretary to calculate the DSH payments in a particular manner, rather than simply remanding. See Allina I Appeal, 746 F.3d 1102, 1111 (D.C. Cir. 2014). On remand, the Secretary addressed the issue of the appropriate DSH calculation methodology through an adjudication. The Administrator determined that, prior to 2004, the regulation did not specify where the Part C enrollees should be counted in the DSH percentage. Allina I, Adm'r Dec. at 26 (Dec. 2, 2015) [Dkt. 28-2]. The Administrator further concluded that the better statutory interpretation is that Part C enrollees are "entitled to benefits under Part A" within the meaning of the DSH provisions, and therefore should be included in the Medicare fraction. Id. at 35-45.

C. Procedural Background

Shortly after our Court of Appeals' decision in Allina I, the Secretary published calculations for federal fiscal year 2012 DSH payments ("2012 DSH Calculations").[1] See 2012 Part A/SSI Fraction Data File, available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY-2012-SSI-Ratios-for-web-posting.zip. Plaintiffs allege that the 2012 DSH Calculations are based on the 2004 Final Rule that was vacated. They also allege that the

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[1] The present action is not considered part of the Allina I remand, because it concerns a later year. In 2013, the HHS adopted a legislative rule that interprets the statute to require Part C days in the Medicare fraction. 78 Fed. Reg. 50,496, 50,614 (Aug. 19, 2013) ("2013 Rulemaking"). The legislative rule only has prospective application, and therefore does not apply to this case or the Allina I remand. Id. at 50,620.

2012 DSH Calculations are procedurally invalid and arbitrary and capricious. Compl. ¶¶ 46-52. Plaintiffs timely appealed the 2012 DSH Calculations to the Provider Reimbursement Review Board ("PRRB"), see Compl. ¶¶ 36-39, and requested that the PRRB grant expedited judicial review. Id. ¶ 41.

The PRRB is an independent administrative tribunal that resolves disputes regarding hospital reimbursement determinations by Medicare contractors or the Centers for Medicare & Medicaid Services ("CMS"). See 42 U.S.C. § 1395oo(a). The PRRB may resolve certain payment disputes without following low-level policy guidance, see 42 C.F.R. § 405.1867; however, it is bound by agency regulation and rulings, id., and cannot decide "question[s] of law or regulations." 42 U.S.C. § 1395oo(f)(1). Section 1395oo(f) gives providers "the right to obtain judicial review of any action . . . which involves a question of law or regulations . . . whenever the [PRRB] determines . . . that it is without the authority to decide the question." Id.

By letter dated August 13, 2014, the PRRB granted Plaintiffs' request for expedited judicial review, finding that "it is without the authority to decide the legal question of whether the regulation regarding the [2012 DSH Calculations] is valid and whether the Secretary's actions subsequent to the decision in Allina [I] are legal." Letter from the Provider Reimbursement Review Board to Stephanie Webster 6 (Aug. 13, 2014) [Dkt. No. 14-1] ("PRRB Decision").

On August 19, 2014, Plaintiffs filed their Complaint, pursuant to the PRRB's grant of expedited judicial review [Dkt. No. 1]. Plaintiffs filed a Notice of Related Case on the same day [Dkt. No. 2]. Judge Collyer

granted Defendant's objection to the related case designation on May 18, 2015, and the case was randomly reassigned to this Court. Minute Order dated May 18, 2015; Case Assignment [Dkt. No. 20].

On October 27, 2014, Defendant filed her Motion to Dismiss for Lack of Jurisdiction or in the Alternative for Voluntary Remand [Dkt. No. 15], arguing that the PRRB improvidently granted expedited judicial review, or in the alternative, for voluntary remand to allow the PRRB to adjudicate Plaintiffs' claims without consideration of the 2004 Final Rule. Motion to Dismiss at 2. The Court denied Defendant's Motion to Dismiss on October 29, 2015 [Dkt. No. 21].

Plaintiffs filed their present Motion for Summary Judgment on September 29, 2014 [Dkt. No. 8], prior to Defendant's response to the Complaint. On October 17, 2014, the Court (Collyer, J.) granted Defendant's Motion to hold in abeyance the Motion for Summary Judgment until the Motion to Dismiss was filed and decided. See October 17, 2014 Minute Order. After this Court denied Defendant's Motion to Dismiss, Defendant filed her Answer on November 12, 2015 [Dkt. No. 24], and her Cross-Motion for Summary Judgment ("Def.'s Mot.") on December 15, 2015 [Dkt. No. 29]. Plaintiffs filed their Opposition ("Opp'n") on January 14, 2016 [Dkt. No. 30] and Defendant filed her Reply ("Reply") on February 4, 2016 [Dkt. No. 33]. On February 12, 2016, Plaintiffs filed a Motion for Leave to File a Sur-Reply [Dkt. No. 34], which Defendant opposed [Dkt. No. 35], and the Court denied on February 18, 2016 [Dkt. No. 36].

II. Legal Standard

A. Motion for Summary Judgment

Summary judgment will be granted when there is no genuine issue as to any material fact. See Fed. R. Civ. P. 56(a). Because this case involves a challenge to a final administrative decision, the Court's review on summary judgment is limited to the administrative record. Holy Land Found. for Relief & Dev. v. Ashcroft, 333 F.3d 156, 160 (D.C. Cir. 2003) (citing Camp v. Pitts, 411 U.S. 138, 142 (1973)); Fund for Animals v. Babbitt, 903 F. Supp. 96, 105 (D.D.C. 1995) ("Summary judgment is an appropriate procedure for resolving a challenge to a federal agency's administrative decision when review is based upon the administrative record").

"Summary judgment thus serves as the mechanism for deciding, as a matter of law, whether the agency action is supported by the administrative record and otherwise consistent with the APA standard of review." Sierra Club v. Mainella, 459 F. Supp. 2d 76, 90 (D.D.C. 2006) (citing Richards v. INS, 554 F.2d 1173, 1177 & n.28 (D.C. Cir. 1977)). In reviewing agency action, the district court "sits as an appellate tribunal, not as a court authorized to determine in a trial-type proceeding whether the Secretary's [action] was factually flawed." Marshall Cnty. Health Care Auth. v. Shalala, 988 F.2d 1221, 1225 (D.C. Cir. 1993).

B. Requirements of the APA and Medicare Act

Under the APA and the Medicare Act, legislative rules—rules that have the "force and effect of law," Chrysler Corp. v. Brown, 441 U.S. 281, 302-303, (1979)) —are issued through notice-and-comment rulemaking, in which the Secretary must provide the public with ad-

equate notice of a proposed rule and an opportunity to comment thereon. See 5 U.S.C. § 553(b)-(c) (APA); 42 U.S.C. § 1395hh(b)(1) (Medicare) ("[B]efore issuing in final form any regulation . . . the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon."). "Notice requirements are designed (1) to ensure that agency regulations are tested via exposure to diverse public comment, (2) to ensure fairness to affected parties, and (3) to give affected parties an opportunity to develop evidence in the record to support their objections to the rule and thereby enhance the quality of judicial review." Int'l Union, UMWA v. MSHA, 407 F.3d 1250, 1259 (D.C. Cir. 2005). The 2012 DSH Calculations were not issued through notice and comment rulemaking, although Plaintiffs argue that they should have been. Pls.' Mot. at 9; Pls.' Reply at 10.

Not all rules require notice-and-comment prior to issuance. Section 4(b)(A) of the APA provides that, unless another statute states otherwise, the notice-and-comment requirement "does not apply" to "interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice." 5 U.S.C. § 553(b)(A). "[T]he critical feature of interpretive rules is that they are 'issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers.'" Perez v. Mortgage Bankers Ass'n, 135 S. Ct. 1199, 1204 (2015) (quoting Shalala v. Guernsey Memorial Hospital, 514 U.S. 87, 99 (1995)).

The D.C. Circuit had long held that, even though notice and comment was not necessary for new interpretive rules issued by an agency, notice and comment

was nonetheless required when an agency changed its prior interpretation. Paralyzed Veterans of Am. v. D.C. Arena L.P., 117 F.3d 579 (1997). Overturning Paralyzed Veterans and its subsequent line of cases, the Supreme Court recently held that an agency need not use notice-and-comment procedures "when it wishes to issue a new interpretation of a regulation that deviates significantly from one the agency has previously adopted." Perez, 135 S. Ct. 1199 at 1203.

The APA also allows a reviewing court to set aside an agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A); Tourus Records, Inc. v. DEA, 259 F.3d 731, 736 (D.C. Cir. 2001). "The scope of review under the 'arbitrary and capricious' standard is narrow and a court is not to substitute its judgment for that of the agency." Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983). The court must "consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." S. Co. Servs., Inc. v. FCC, 313 F.3d 574, 579-80 (D.C. Cir. 2002); see also United States v. Paddack, 825 F.2d 504, 514 (D.C. Cir. 1987) .

An agency satisfies the arbitrary and capricious standard if it "examine[s] the relevant data and articulate[s] a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" Motor Vehicle Mfrs. Ass'n, 463 U.S. at 43 (quoting Burlington Truck Lines v. United States, 371 U.S. 156, 168 (1962)); Lichoulas v. FERC, 606 F.3d 769, 775 (D.C. Cir. 2010). However, courts "do not defer to the agency's conclusory or unsupported suppositions."

McDonnell Douglas Corp. v. U.S. Dep' t of the Air Force, 375 F.3d 1182, 1186-87 (D.C. Cir. 2004).

III. Analysis

A. The Evidence Is Not Convincing that CMS Calculated the 2012 DSH Fractions Based on the Vacated 2004 Final Rule.

Plaintiffs argue that the Secretary improperly relied on the vacated 2004 Final Rule to formulate the 2012 DSH Calculations, Pls.' Mot. at 6-7, while Defendant counters that the 2012 DSH Calculations were reached by CMS in reliance on the language of the disproportionate patient percentage statute itself. Def.'s Mot. at 9.

What is central to this dispute is the parties' disagreement as to the impact of the vacatur of the 2004 Final Rule. Defendant argues that "the agency was faced with an ambiguous direction from Congress" and that the pre-2004 version of the applicable regulation did not specify where Part C days should be counted. Id. at 10. Plaintiffs on the other hand argue that pre-2004, the agency had a policy of excluding Part C days from the Medicare fraction. Pls.' Reply at 4. In the alternative, Plaintiffs argue that even if there was not a policy or regulation excluding Part C days from the Medicare fraction, the agency had a prior practice of excluding the Part C days, which was reinstated after the vacatur of the 2004 Final Rule. Id. (citing Croplife Am. v. EPA, 329 F.3d 876, 880, 884-85 (D.C. Cir. 2003).

Defendant contends that there is no evidence to directly suggest that the 2012 DSH Calculations were based on the vacated 2004 Final Rule, rather than on CMS's interpretation of the statute. Def.'s Mot. at 10. Conversely, Plaintiff argues that there is no evidence

to suggest that the Secretary did not rely on the vacated rule. The Secretary states that CMS "inevitably had to employ one of two possible interpretations of the statutory language," and the one it chose for the 2012 DSH Calculations reflected CMS's best understanding of the statutory language itself. Def.'s Mot. at 10 (citing Declaration of Ing Jye Cheng ("Cheng Decl.") ¶¶ 7, 8 [Dkt. No. 29-3]). Acknowledging that the 2004 Final Rule is no longer in effect, the Secretary cites to the Allina I Administrator decision as evidence that the agency is no longer relying on the vacated 2004 Final Rule. Id.

Our Court of Appeals, in remanding Allina I to allow the agency to consider the interpretive issue anew, made it clear that it was possible the agency could and might adopt the same interpretation contained in the 2004 Final Rule. Allina I Appeal, 746 F.3d at 1111. Consequently, it follows that the fact that the agency did adopt the same interpretation as the 2004 Final Rule is not—in and of itself—indicative that the 2004 Final Rule was relied upon.

While it may have been far better if the agency had provided an explanation of its interpretation of the DSH statute along with the 2012 DSH Calculations, particularly in light of the vacatur of the 2004 Final Rule, there is no con incing evidence that Defendant actually relied on the vacated rule in promulgating the 2012 DSH Calculations. Indeed, as the Court later concludes, the Secretary appropriately relied on and interpreted the underlying DSH statute to calculate the 2012 DSH Calculations.

B. Notice and Comment Rulemaking Was Not Required

i. The APA

The parties agree that the Secretary did not undertake notice and comment rulemaking to implement a rule including Part C days in the Medicare fraction that is applicable to the 2012 DSH Calculations. The issue is whether the Secretary should have.

The APA requires notice and comment when agencies implement new legislative rules. 5 U.S.C. § 553(b). Plaintiffs argue that the 2012 DSH Calculations were not a one-time decision, but instead were the beginning of an ongoing pattern and therefore should be considered a legislative rule. Pls.' Reply at 23. Plaintiffs reason that the 2012 DSH Calculations "'reflect' a universal policy of treating part C days as part A days for all hospitals," because the agency has continued to include Part C days in the Medicare fraction in all future actions. Id. Therefore, Plaintiffs continue, the 2012 DSH Calculations constitute "an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy," and are therefore a "rule" for purposes of the APA Id. (citing 5 U.S.C. § 551(4)).

Defendant takes issue with the characterization of the 2012 DSH Calculations as involving a rule at all. The 2012 DSH Calculations are comprised solely of a spreadsheet of percentages,[2] which Defendant charac-

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[2] The 2012 DSH Calculations are available at http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/Downloads/FY-2012-SSI-Ratios-for-web-posting.zip.

terizes as "preliminary, provider-specific determinations calculated on the basis of services that had already been rendered." In other words, Defendant argues that the 2012 DSH Calculations are more appropriately viewed as a step in an adjudication rather than as a rule. Def.'s Mot. at 12.

However, Defendant acknowledges that the fractions "do reflect an interpretation of the statute that Part C days are included in the Medicare fraction." Id. (emphasis in original). The 2012 DSH Calculations were not merely a step in an adjudication, but reflect a decision by the agency to include Part C days in the Medicare fraction. Thus, the 2012 DSH Calculations are not appropriately viewed as a step in an adjudication but rather as a rule.

The Court must now determine whether the agency was announcing a new legislative rule or simply interpreting the statute and announcing an interpretive rule. A "legislative rule," is a rule intended to have and does have the force of law. "A valid legislative rule is binding upon all persons, and on the courts, to the same extent as a congressional statute. When Congress delegates rulemaking authority to an agency, and the agency adopts legislative rules, the agency stands in the place of Congress and makes law. An 'interpretative' rule, by contrast, does not contain new substance of its own but merely expresses the agency's understanding of a congressional statute." Nat'l Latino Media Coal. v. F.C.C., 816 F.2d 785, 787-88 (D.C. Cir. 1987).

Factors to consider when determining whether a rule has a "legal effect" include "asking 1) whether in the absence of the rule there would not be an adequate legislative basis for enforcement action or other agency

action to confer benefits or ensure the performance of duties, (2) whether the agency has published the rule in the Code of Federal Regulations, (3) whether the agency has explicitly invoked its general legislative authority, or (4) whether the rule effectively amends a prior legislative rule. If the answer to any of these questions is affirmative, we have a legislative, not an interpretive rule." Am. Min. Cong. v. Mine Safety & Health Admin., 995 F.2d 1106, 1112 (D.C. Cir. 1993).

The answer to all of the above questions is "no." As our Court of Appeals has previously recognized, the DSH statute is ambiguous and could be interpreted to include or exclude Part C days. Ne. Hosp., 657 F.3d at 5-6. The fact that the statute could be interpreted to include Part C days indicates that there is an adequate legislative basis for the agency's decision. The rule of including Part C days in the Medicare fraction, as applied to the 2012 DSH Calculations, was not published in the Code of Federal Regulations, nor did the agency explicitly invoke its legislative authority. Lastly, the rule does not amend a prior legislative rule.[3]

For these reasons, the Court concludes that the agency did not issue a legislative rule when it issued the 2012 DSH Calculations, and therefore APA notice and comment were not necessary. Instead, the 2012 DSH Calculations constitute the agency's interpreta-

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[3] Plaintiffs argue that the agency had a prior policy, rather than simply a practice, of excluding Part C days. See Pls.' Opp'n at 7-8. The facts do not support a finding of a policy, rather than simply a practice. Even if the agency did have a prior policy, it would not have been a legislative policy requiring notice and comment to change it.

tion of the disproportionate patient percentage statute. The statute itself provides an "adequate legislative basis" for including Part C days in the Medicare fraction, and therefore the rule underlying the 2012 DSH Calculations is interpretive. See Am. Min. Cong., 995 F.2d at 1112.

Plaintiffs argue that, because the agency previously promulgated the same interpretation through notice and comment rulemaking in the 2004 Final Rule and the 2013 Rulemaking, it should continue to do so for the 2012 DSH Calculations. Pls.' Reply at 28-30. However, there is no requirement that the agency continue to do so. For example, an agency may choose to invoke its general legislating authority out of an abundance of caution. Am. Min. Cong., 995 F.2d at 1110-11. Therefore, the agency's prior invocation of its general legislating authority (here, the 2004 Final Rule), is not per se evidence that it needed to do so and does not negate the Court's finding that the agency's action was interpretive.

ii. The Medicare Statute

The Medicare statute also requires notice and comment prior to the Secretary issuing final regulations. See 42 U.S.C. § 1395hh(b). Plaintiffs argue that the Medicare statute requires "rulemaking for a more expansive set of agency pronouncements than the APA." Pls.' Reply at 11. Plaintiffs cite to no cases in support of their argument and the Court finds their statutory interpretation arguments unpersuasive. Pls. Reply at 11-13.

Our Court of Appeals has not decided whether the Medicare statute "creates a more stringent obligation [than the APA] or whether it somehow changes the

dividing line between legislative and interpretive rules." Monmouth Med. Ctr. v. Thompson, 257 F.3d 807, 814 (D.C. Cir. 2001). However, the Court of Appeals did note that, because the Medicare statute was adopted after the APA, it was fair to infer that "§ 1385hh(c)'s reference to, 'interpretive rules' without any further definition adopted an exemption [to notice and comment requirements] at least similar in scope to that of the APA." Id. (internal citation omitted). Other circuit courts have similarly concluded, though without thorough analysis, that the standards imposed by the APA and Medicare are not materially different. See Baptist Health v. Thompson, 458 F.3d 768, 776 (8th Cir. 2006) (42 U.S.C. § 1395hh(a)(2) "imposes no standards greater than those established by the APA."); Erringer v. Thompson, 371 F.3d 625, 633 (9th Cir. 2004) (declining to determine whether the Medicare Act "draws the line between substantive and interpretive rules in a different place than the APA"); Warder v. Shalala, 149 F.3d 73, 79 n.4 (1st Cir. 1998) ("the [Medicare statute's] language, drafted after the APA's, can fairly be read to duplicate the APA on this score.").

Even if the Medicare statute was more demanding, the Secretary's interpretation of the DSH statute is not a "rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard" such that notice and comment would be required. See 42 U.S.C. § 1395hh(a)(2). As discussed previously, in the absence of any regulation or rule, there is an "adequate legislative basis" for the Secretary's interpretation and application of the statute. American Mining Congress, 995 F.2d at 1112. The agency's interpretation of the statute does not require rulemaking under the Medicare statute.

iii. Rulemaking Through Adjudication

Defendant argues that notice and comment rulemaking is not necessary because it is "well-established that an agency may employ a new interpretation in the course of an individual adjudication." Def.'s Mot. at 12 (citing Shalala v. Guernsey Mem'l Hosp., 514 U.S. 87, 97 (1995) ("The APA does not require that all the specific applications of a rule evolve by further, more precise rules rather than by adjudication. The Secretary's mode of determining benefits by both rulemaking and adjudication is, in our view, a proper exercise of her statutory mandate" (internal citations omitted))); see also Clark-Cowlitz Joint Operating Agency v. FERC, 826 F.2d 1074, 1081 (D.C. Cir. 1987) (en banc) ("[W]hen as an incident of adjudicatory function an agency interprets a statute, it may apply that new interpretation in the proceeding before it."). Defendant also points out that the decision whether to make new policy through adjudication or rulemaking is generally within the agency's discretion. Id. at 13 (citing NLRB v. Bell Aerospace Co. Div. of Textron, 416 U.S. 267, 291-94 (1974)). Given this, authority, Defendant concludes that it was "well within CMS's discretion to employ the interpretation it did in the course of calculating the 2012 [DHS Calculations]." Id.

Whether or not Defendant can issue new interpretations through adjudication is not relevant to this case, because the agency did not engage in an adjudication to reach the 2012 DSH Calculations. Defendant attempts to rely on a 2007 adjudication as authority for its policy in the 2012 DSH Calculations, but this reliance is misplaced. Def.'s Mot. at 14 (citing St. Joseph's Hosp. v. Blue Cross/Blue Shield Ass'n, 2007 WL 4861952 at *5

(Nov. 13, 2007)). St. Joseph's was not a forward looking policy and was limited to fiscal years 1998, 1999, and 2000. St. Joseph's Hosp., 2007 WL 4861952 at *1. In addition, the PRRB reached its decision, later affirmed by the Administrator, with reference to the now vacated 2004 Final Rule, which calls into question any prospective validity St. Joseph's may have had. See PRRB Decision (Aug. 27, 2004), available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/2007d68.pdf

Therefore, an agency's ability to issue new interpretive rules through adjudication does not help Defendant's case here.

iv. Prior Definitive Interpretation

As discussed previously, in Perez, the Supreme Court overruled the Court of Appeals' Paralyzed Veterans doctrine, which had created a judge-made procedural requirement that an agency use notice-and-comment rulemaking whenever it changed a rule interpreting a statute, even though such notice-and-comment would not have been required when interpreting the statute in the first instance. See supra, 12. Plaintiffs acknowledge that changes to an interpretive rule are no longer subject to notice and comment under the APA, and have withdrawn that argument. See Pls.' Reply at 16 n.10.

Even so, Plaintiffs contend that a "policy that 'works substantive changes' or makes 'major substantive legal additions' to existing regulations requires notice and comment.' Pls.' Reply at 19 (quoting U.S. Telecom Ass'n v. FCC, 400 F.3d 29, 34-35 (D.C. Cir. 2005)). Plaintiffs argue that the 2012 DSH Calculations effected

a substantive change and therefore should have undergone notice and comment procedures. Id. at 19-20. This argument misunderstands U.S. Telecom, which does not stand for the proposition that there are certain instances where interpretive rules require notice and comment. Rather, it held that new rules that affect substantive changes or amend prior legislative rules may more appropriately be considered legislative rules rather than interpretive rules. U.S. Telecom Ass'n, 400 F.3d at 34-35. The Court has already determined that the policy that was effectively announced in the 2012 DSH Calculations was an interpretive one, not legislative. See supra 19. Because the agency's action was interpretive, notice and comment was not required.

C. The Decision to Include Part C Days Is Not Arbitrary and Capricious

Plaintiffs argue that the Secretary's decision to include Part C days in the Medicare fraction was arbitrary and capricious. See Pls.' Reply at 32. Plaintiffs' contention has two prongs: first, that the agency's "no-process determination for all hospitals" is arbitrary and capricious, and second, that the agency's decision is impermissibly inconsistent with the underlying statutory scheme. Id. at 32-33.

As to the first, Plaintiffs contend that the Secretary's policy determination is arbitrary and capricious because the agency has not "articulated any rationale for its choice." Pls. Reply at 33 (quoting Republican Nat'l Comm. v. FEC, 76 F.3d 400, 407 (D.C. Cir. 1996). The scope of review under the arbitrary and capricious standard is a narrow one. The Court is not to substitute its own judgment, but the "agency must examine

the relevant data and articulate a satisfactory explanation for its action." Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 42-43 (1983). The court may not supply reasoning that the agency itself has not provided. Id. at 43. However, the court will "uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned." Id. (quoting Bowman Transp. Inc. v. Arkansas-Best Freight Sys., 419 U.S. 281, 286 (1974)).

Defendant blames the absence of a contemporaneous explanation for its decision to include Part C days in the Medicare fraction in the 2012 DSH Calculations on the unique posture of the case. Def.'s Mot. at 25-26. Defendant explains that the agency expected further administrative proceedings in connection with the challenge and regarded the decision as non-final. Id. at 26. Even if the Defendant expected "further administrative development" before the PRRB and Administrator, id., it is not clear why the agency would not provide any contemporaneous explanation with the issuance of the 2012 DSH Calculations. The agency also contends it was a one-time interpretive decision and as such, Plaintiffs are not entitled to expect an explanation of the sort that CMS would provide for a final prospective rule. Id.

Despite the lack of explanation, Defendant argues that the interpretative choice "can be readily sustained on the basis of the explanation set forth in the Administrator's decision in the Allina I remand." Id. at 27. Defendant concedes that the Court's review is ordinarily limited to the contemporaneous record developed by the agency, but argues that an exception is warranted. Id. (citing SEC v. Chenery Corp., 318 U.S. 80 (1943);

Glob. Crossing Telecomms., Inc. v. Metrophones Telecomms., Inc., 550 U.S. 45, 63-64 (2007)).

Chenery stands for the proposition that "an agency's decision must reflect the reasons for its action, and that subsequent rationalizations cannot be substituted on appeal for contemporaneous reasoned decisionmaking." Pub. Serv. Co. of Indiana v. I.C.C., 749 F.2d 753, 759 (D.C. Cir. 1984) (citing Chenery, 318 U.S. at 92-95). But Chenery is not absolute. In Global Crossing, the Supreme Court found that the FCC's initial opinion did not explain its determination, but nevertheless upheld the determination, finding that the "context and cross-referenced opinions ma[d]e the FCC's rationale obvious." Glob. Crossing Telecomms., 550 U.S. at 63 (internal citations omitted).

The Secretary argues that the instant case is akin to Global Crossing in that the Administrator's Allina I decision provides evidence of the agency's reasoning and therefore the agency's rationale is adequately explained. Def.'s Reply at 27. However, the Administrator's Decision, which was issued in December 2015, was not yet issued at the time of the 2012 DSH Calculations, which were issued in 2014. Although the 2013 Rulemaking had been issued, it is prospective only. See 78 Fed. Reg. 50,496, 50,614 (Aug. 19, 2013). In addition, unlike Global Crossing, the 2012 DSH Calculations do not include any cross-references to opinions or documents that shed light on the agency's rationale.

Defendant argues that it "'would be a waste of time to review only' the contemporaneous agency record to the 2012 DSH Calculations when the agency has subsequently issued in 2015 a 'better considered' decision upon which review may be based." Def.'s Mot. at 28

(quoting Pub. Serv. Co., 749 F.2d at 760). Public Service is easily distinguished from the case at hand, as it involved a clarifying opinion. The Commission had provided a first opinion, but then at the request of the petitioners to reopen the decision, reconsidered the record and issued a second clarifying opinion. The issue there was whether the second opinion could be considered. Such is not the case here. The Administrator's Allina I decision is precisely the type of post-hoc rationalization that Chenery says cannot be substituted on appeal for contemporaneous, reasoned decision-making. Chenery, 318 U.S. at 92-95.

The dangers of post-hoc rationalizations for agency action are that the judiciary, rather than the agency, will supply the reasons underlying the action and that the "real reasons for agency action will escape judicial scrutiny altogether." Women Involved in Farm Econ. v. U.S. Dep't of. Agric., 876 F.2d 994, 1000 (D.C. Cir. 1989). These concerns are not present here. Here, the agency has supplied its reasons on multiple occasions, including the Administrator's recent decision and the 2013 Rulemaking. This is also not a case where the agency's reasoning will escape judicial review given that the issue has been before the courts on multiple occasions, as demonstrated in this opinion. See infra, 29-30.

Viewing the situation in its entirety, the Court concludes that the process underlying the 2012 DSH Calculations was not arbitrary and capricious. Although the agency gave no explicit contemporaneous explanation, the concerns for post-hoc rationalization are not present. The agency had made its interpretation of the statute clear in the 2004 Final Rule, although that rule was later vacated, and the 2013 Regulation, and

has also subsequently made it clear in the Administrator's decision. Although no explanation accompanied the 2012 DSH Calculations, it is not difficult to understand the agency's reasoning, there is no concern that subsequent rationalizations are substituting contemporaneous reasoned decisionmaking, nor is there a concern that the judiciary is providing the reasons for the agency's action, rather than the agency.

Turning to Plaintiffs' second allegation that the Secretary's interpretation is inconsistent with the statute, our Court of Appeals has already held that the statutory text does not foreclose the Secretary's interpretation. Ne. Hosp. Corp., 657 F.3d at 13. In evaluating the same question of whether Part C enrollees are entitled to benefits under Part A, the Northeast Hospital court stated, at step 1 of the Chevron analysis, that "Congress ha[d] not clearly foreclosed the Secretary's interpretation that [Part C] enrollees are entitled to benefits under Part A." Id. While Northeast Hospital found that the Secretary's interpretation was not foreclosed by the statute, it did not reach the Chevron step 2 analysis to determine if the Secretary's interpretation was reasonable. See Ne. Hosp. Corp., 657 F.3d at 13. The Northeast Hospital court held that it was for the Secretary, not the Court, to determine the proper interpretation. Id. That is precisely what the Secretary has done in this instance.

In Catholic Health Initiatives v. Sebelius, the Court considered the phrase "entitled to benefits under Part A," also key to the case at hand, though not in the context of Part C days. 718 F.3d 914, 917 (2013). The Secretary argues that the Court's decision in Catholic Health is instructive here, Def.'s Mot. at 32, as the

Court deferred under Chevron step 2 to the Secretary's interpretation that "entitlement" is "simply a matter of meeting the statutory criteria, not a matter of receiving payment." Catholic Health, 718 F.3d at 919-920.

Plaintiffs offer no meaningful distinction between the case at hand and Catholic Health. See Pls.' Reply at 30-31, 39. Although the type of days specifically at issue are different, the core dispute is the same. Defendant argues that "entitlement" refers simply to meeting the statutory requirements, Def.'s Mot at 31, while Plaintiffs argue that "entitlement" requires the ability to be paid under Part A. Pls.' Reply at 3, 39-40. The Catholic Health Court deferred to the agency's interpretation, and that deference is applicable to this case as well.

In light of our Court of Appeals' decisions in Northeast Hospital and Catholic Health, as well as the narrow standard of review, the Court concludes that the Secretary's interpretation that patients enrolled in Part C continue to be "eligible" for Part A is well within her authority and not arbitrary and capricious.

IV. Conclusion

For the foregoing reasons, Plaintiffs' Motion for Summary Judgment shall be denied and Defendant's Motion for Summary Judgment shall be granted. An Order shall accompany this Memorandum Opinion.

Aug. 17, 2016 /s/ GLADYS KESSLER
GLADYS KESSLER
United States District Judge

Copies to: attorneys on record via ECF

APPENDIX C

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 14-1415 (GK)

ALLINA HEALTH SERVICES, ET AL., PLAINTIFFS

v.

SYLVIA M. BURWELL, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEFENDANT

[Filed: Aug. 17, 2016]

ORDER

Plaintiffs Allina Health Services, et al. ("Plaintiffs") are nine hospitals that bring this action against Sylvia M. Burwell, in her official capacity as Secretary of the United States Department of Health and Human Services ("Secretary" or "Defendant"). They challenge the calculation of certain disproportionate share hospital payments as procedurally and substantively invalid.

This matter is before the Court on the Plaintiff's Motion for Summary Judgment [Dkt. No. 8] and Defendant's Cross-Motion for Summary Judgment [Dkt. No. 28]. Upon consideration of the Motions, Oppositions, Replies, the entire record herein, and for the reasons set forth in the accompanying Memorandum Opinion, it is hereby

ORDERED, that Plaintiffs' Motion for Summary Judgment is **denied**; and it is further

ORDERED, that Defendant's Motion for Summary Judgment is **granted.**

Aug. 17, 2016 /s/ GLADYS KESSLER
GLADYS KESSLER
United States District Judge

Copies to: attorneys on record via ECF

APPENDIX D

**DEPARTMENT OF HEALTH
AND HUMAN SERVICES
PROVIDER REIMBURSEMENT
REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670**

Internet: www.cms.gov/PRRBReview

**Phone: 410-786-2671
FAX: 410-786-5298**

Refer to: 14-3736G, 14-3813GC
Certified Mail [Aug. 13, 2014]

Stephanie A. Webster, Esq.
Akin, Gump, Strauss, Hauer & Feld
Robert S. Strauss Building
1333 New Hampshire Avenue, NW
Washington, DC 20036-1564

RE: Akin Gump 2012 Post-Allina Decision Medicare Part C Days Group, Provider Nos. Various, FY 2012, PRRB Case No. 14-3736G
Allina Health 2012 Post-Allina Decision Medicare Part C Days, Provider Nos. Various, FY 2012, PRRB Case No. 14-3813GC

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' July 17, 2014 request for expedited judicial review (EJR) (received July 18, 2014) in case number 14-3736G and the July 25, 2014 EJR request (received July 28, 2014) in case number 14-3813GC.

The Board decision granting the request for EJR is set forth below.

Issue before the Board

The issue before the Board in these cases is whether "enrollees in [Medicare] Part C are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction [of the disproportionate share (DSH) adjustment], or whether, if not regarded as 'entitled to benefits under Part A,' they should instead be included in the Medicaid fraction of the DSH adjustment."[1]

Background on Medicare Part C

Medicare Health Maintenance Organizations and the Medicare Advantage Program[2, 3]

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health

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[1] Providers' Requests for EJR at 4.

[2] *See http://www.medicare.gov/glossary/m.html.* (A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide beneficiaries with all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If a beneficiary is enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.) (last visited August 4, 2014).

[3] *See http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/* (The [Medicare + Choice (M+C)] program in Part C of Medicare was renamed the Medicare Advantage (MA) Program under the Medicare Prescription Drug, Improvement, and Modernization Act

maintenance organizations (HMOs) and competitive medical plans (CMPs) is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days. In the September 4, 1990 Federal Register, the Secretary[4] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have

---

of 2003 (MMA), which was enacted in December 2003. The MMA further established the Medicare prescription drug benefit (Part D) program, and amended the Part C program to allow most MA plans to offer prescription drug coverage.) (last visited August 4, 2014).

[4] of Health and Human Services.

> been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[5]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[6]

With the creation of Medicare Part C in 1997,[7] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the intermediaries to calculate DSH payments for the FY 2001-2004.[8]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the Federal fiscal year (FFY) 2004 Inpatient Prospective Payment System (IPPS) proposed rules were published in the May 9, 2003 Federal Register. In that notice the Secretary stated that:

> . . . an individual is eligible to elect an M+C plan if he or she is entitled to Medicare Part A and enrolled in Part B. However, once a beneficiary has

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[5] 55 Fed. Reg. 35,990, 39,994 (September 4, 1990).

[6] *Id.*

[7] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.—An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ."

[8] 69 Fed. Reg. 48,918, 49,099 (August 11, 2004).

> elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.*[9]

The Secretary purportedly changed her position in the FFY 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R] § 412.106(b)(2)(i) to include the days associated with [M+C] beneficiaries in the Medicare fraction of the DSH calculation."[10] In response to a comment regarding this change, the Secretary explained that:

> . . . *we do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI

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[9] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003) (emphasis added)

[10] 69 Fed. Reg. 49,098, 49,099 (August 11, 2004).

> recipient, the patient days will be included in the numerator of the Medicare fraction.[11]

Although change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until the FFY 2008 final rule was published in the August 22, 2007 Federal Register.[12] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule, published in the August 11, 2004 Federal Register. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004. In this Federal Register notice the Secretary stated that:

> In the FY 2005 IPPS final rule (69 FR 49099), we discussed in the preamble our policy change to reflect the inclusion of the days associated with Medicare+ Choice (now Medicare Advantage) beneficiaries under Medicare Part C in the Medicare fraction of the DSH calculation. In that rule, we indicated that we were revising the regulation text at [42 C.F.R] § 412.106(b)(2)(i) to incorporate this policy. However, we inadvertently did not make a change in the regulation text to conform to the preamble language. We also inadvertently did not propose to change § 412.106(b)(2)(iii) in the FY 2005 final rule, although we intended to do so. Section 412.106(b)(2)(i) of the regulations discusses the numerator of the Medicare

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[11] *Id. (emphasis added)*

[12] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).

fraction of the Medicare disproportionate patient percentage (DPP) calculation while § 412.106(b)(2)(iii) of the regulations discusses the denominator of the Medicare fraction of the Medicare DPP. We intended to amend the regulation text with respect to both the numerator and the denominator of the Medicare fraction of the Medicare DPP. Therefore, in this final rule with comment period, we are making this technical correction to § 412.106(b)(2)(i) and to § 412.106(b)(2)(iii) to make them consistent with the preamble language of the FY 2005 IPPS final rule and to effectuate the policy iterated in that rule.

With respect to the technical correction that we are making to § 412.106(b)(2)(iii), we note that we ordinarily publish a notice of proposed rulemaking in the Federal Register to provide for a period for public comment before a provision such as this would take effect. However, we can waive this procedure if an agency finds good cause that a notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the notice issued. We find it unnecessary to undertake notice and comment rulemaking in this instance for the additional change to § 412.106(b)(2)(iii) because this notice merely provides technical corrections to the regulations and does not make any substantive changes to the regulations or our existing policy. Therefore, under 5 U.S.C. 533(b)(B), for good cause, we waive notice and comment procedures.[13]

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[13] *Id.*

Federal Court Decisions in *Allina Health Services v. Sebelius (Allina)*[14]

In the District Court decision in *Allina* the Court concluded that the Secretary's interpretation of the fractions used in the DSH calculation and not added to the Code of Federal Regulations until the summer of 2007 (FFY 2008) were not a logical outgrowth of the notice of proposed rulemaking in 2003. In fact, the Secretary's actions were a 180-degree shift in position and a reasonable person would not have understood that such a conclusion would be reached. The Court found that the 2003 notice of proposed rulemaking did not provide adequate notice of the interpretation of the DSH fraction adopted by the Secretary in 2004 in violation of the Administrative Procedures Act and Medicare Act. The Court determined that vacatur was appropriate because the Secretary did not validly change her interpretation of the DSH calculation prior to 2007 and ordered recalculation without using the interpretation in the 2004 rule.[15]

On appeal, the D.C. Circuit Court[16] affirmed the vacatur, but determined that remanding for payment without using the 2004 Final Rule was not correct. Rather than telling the Secretary how to calculate the hospitals' reimbursement, the case should have been remanded with the error identified. The Circuit Court limited its ruling to finding that the change to the policy was not a logical outgrowth of the proposed rule. The Secretary had argued that she might obtain the same

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[14] 904 F. Supp. 2d 75 (D.D.C. 2012)

[15] *Id.* at 95.

[16] 746 F.3d. 1102 (D.C. Cir. 2014).

result [application of the invalid rule] through adjudication and since that issue was not before the court, the district court erred in ordering recalculation.[17]

Providers' Requests for EJR

The Providers explain that they were all participants in the *Allina* cases[18] discussed above in which the Federal courts vacated the Secretary's 2004 change to the treatment of Medicare Part C days in the DSH calculation. The Providers were all reimbursed by applying the regulation that was invalidated by the Courts. They are seeking an expeditious ruling on whether the rule remains valid and applicable after the *Allina* decisions or whether the Secretary's actions constitutes unlawful nonacquiecence of binding D.C. Circuit law and a violation of statutory procedural requirements. The Providers do not believe the Board has the authority to grant the relief sought.

The Providers note that in 2013 the Secretary recalculated the Part A/SSI fractions for FFYs 2010 and 2011 for all hospitals nationwide to include Part C days. However, in accordance with the Court's vacatur of the 2004 rule, the Secretary calculated revised fractions for the Providers that excluded the Part C days consistent with the pre-2004 policy. In addition, while *Allina* was pending in the courts, the Secretary engaged in rule making by issuing a new notice and comment stating

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[17] *Id.* at 1111.

[18] Generally, the *Allina* cases heard in the District of Columbia district and circuit courts involve the FFYs 2007 and 2008. The current cases involve later FFYs.

that the agency proposed to readopt the policy of counting Part C days in the Medicare fraction.[19]

Although the time for the Secretary to file a petition for *certiorari* from the *Allina* decision expired June 30, 2014, the Secretary has not issued a notice acquiescing in the D.C. Circuit Court's vacatur. In mid-June of 2014, the agency published the Part A/SSI fractions for 2012, including Part C days for all hospitals. The Providers notified the Secretary of their view that the inclusion of Part C days in the Medicare fraction violated the D.C. Circuit court's decision and new fractions should be calculated. The Providers indicate the Secretary responded that new fractions would not be calculated. The Providers contend that the vacatur restores the previously governing policy until there is a change through valid rulemaking.

Decision of the Board

The Board finds that EJR is appropriate for the issue under dispute in these cases. 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit expedited judicial review where the Board determines that has jurisdiction over the appeal but it does not have the authority to decide a question of law, regulation or CMS ruling. In this case, the Providers are challenging the whether "enrollees in [Medicare] Part C are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction [of the DSH adjustment], or whether, if not regarded as 'entitled to bene-

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[19] *See* 78 Fed. Reg. 50,496, 50,615 (August 19, 2013).

fits under Part A,' they should instead be included in the Medicaid fraction of the DSH adjustment."[20]

The Board has reviewed the submissions of the Providers pertaining to the request for hearing and expedited judicial review. The Intermediary did not oppose the request for EJR. The documentation shows that the estimated amount in controversy exceeds $50,000 for a group appeal and the appeals were timely filed. In addition, the Providers protested the issue on their as-filed cost reports as required by 42 C.F.R. § 405.1835(a)(1)(ii).

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' unopposed assertions regarding the Medicare Part C issue and the Secretary's actions subsequent to the decision in *Allina*, there are no findings of fact for resolution by the Board;

3) it is bound by the regulation; and

4) it is without the authority to decide the legal question of whether the regulation regarding the treatment of Medicare Part C days is valid and whether the Secretary's actions subsequent to the decision in *Allina* are legal.

Accordingly, the Board finds that the Medicare Part C days issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provid-

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[20] Providers' Requests for EJR at 4.

er's request for expedited judicial review for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Board Members Participating

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:
/s/ MICHAEL W. HARTY
MICHAEL W. HARTY
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1), Schedules of Providers

cc: Kyle Browning, NGS (w/Schedules of Providers)
Danene Hartley, NGS (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

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Schedule of Providers in Group

Group Name: Akin Group 2012 Post-Allina Decision Medicare Part C Days Group

Page No. 1 of 2

Representative: Akin Gump Strauss Hauer & Feld LLP

Date Prepared 7/14/2014

Case No: 14-3726G

Issue: Whether Medicare Part C days were properly treated in the calculation of the Medicare DSH payment.

Lead Intermediary: National Government Services

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	10-0128	Tampa General Hospital (Tampa, Hillsborough, FL)	First Coast Service Options - FL	9/30/2013	5/1/2014^	7/1/2014	122	N/A	$1,543,359	Direct Add	7/1/2014
2	33-0059	Montefiore Medical Center (Bronx, Bronx, NY)	National Government Services	12/31/2012	6/3/2014^	7/1/2014	28	N/A	$15,080,768	Direct Add	7/1/2014
3	10-0034	Mount Sinai Medical Center (Miami Beach, Dade, FL)	First Coast Service Options - FL	12/31/2012	5/28/2014^	7/8/2014	41	N/A	$4,717,393	Direct Add	7/8/2014
4	33-0055	New York Hospital Queens (Flushing, Queens, NY)	National Government Services	12/31/2012	6/5/2014^	7/8/2014	33	N/A	$7,932,982	Direct Add	7/8/2014
5	33-0256	New York Methodist Hospital (Brooklyn, Kings, NY)	National Government Services	12/31/2012	6/5/2014^	7/8/2014	33	N/A	$7,333,087	Direct Add	7/8/2014

^ There is no final determination. This date is one year from the date of cost report receipt, which is when the 180 day appeal clock starts to run.

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Schedule of Providers in Group

Group Name: Alda Group 2012 Post-Allina Decision Medicare Part C Days Group — Page No. 2 of 2

Representative: Alda Group/ Stevens Hazzer & Feld LLP — Date Prepared 7/11/2014

Case No: 14-3726G

Issue: Whether Medicare Part C days were properly treated in the calculation of the Medicare DSH payment.

Lead Intermediary: National Government Services

Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Req Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
6 33-0101	New York Presbyterian Hospital (New York, New York, NY)	National Government Services	12/31/2012	6/3/2014[A]	7/14/2014	41	N/A	$8,537,575	Direct Add	7/14/2014

Total Amount of Reimbursement: $45,115,060

[A] There is no final determination. This date is one year from the date of cost report receipt, which is when the 180 day appeal clock starts to run.

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PRRB

Schedule of Providers in Group

Group Name: Allina Health 2012 Post-Allina Decision Medicare Part C Days Group

Page No. 1 of 1

Representative: Akin Gump Strauss Hauer & Feld LLP

Date Prepared 7/25/2014

Case No: Not Yet Assigned 14-3813GC

Issue: Whether Medicare Part C days were wrongly treated in the calculation of the Medicare DSH payment.

Lead Intermediary: National Government Services

Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1 24-0056	United Hospital (St. Paul, Ramsey, MN)	National Government Services	12/31/2012	6/3/2014*	7/25/2014	52	N/A	$812,946	Direct Add	7/25/2014
2 24-0057	Abbott Northwestern Hospital (Minneapolis, Hennepin, MN)	National Government Services	12/31/2012	5/24/2014*	7/25/2014	62	N/A	$1,948,054	Direct Add	7/25/2014
3 24-0132	Unity Hospital (Fridley, Anoka, MN)	National Government Services	12/31/2012	5/24/2014*	7/25/2014	62	N/A	$613,541	Direct Add	7/25/2014

Total Amount of Reimbursement: $3,374,541

*There is no final determination. This date is one year from the date of cost report receipt, which is when the 120 day appeal clock starts to run.

APPENDIX E

**DEPARTMENT OF HEALTH
AND HUMAN SERVICES
PROVIDER REIMBURSEMENT
REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670**

Internet: www.cms.gov/PRRBReview

**Phone: 410-786-2671
FAX: 410-786-5298**

Refer to: 14-3736G, 14-3813GC
Certified Mail [Aug. 13, 2014]

Stephanie A. Webster, Esq.
Akin, Gump, Strauss, Hauer & Feld
Robert S. Strauss Building
1333 New Hampshire Avenue, NW
Washington, DC 20036-1564

RE: Akin Gump 2012 Post-Allina Decision Medicare Part C Days Group, Provider Nos. Various, FY 2012, PRRB Case No. 14-3736G
Allina Health 2012 Post-Allina Decision Medicare Part C Days, Provider Nos. Various, FY 2012, PRRB Case No. 14-3813GC

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14-3813GC. The Board decision granting the request for EJR is set forth below.

Issue before the Board

The issue before the Board in these cases is whether "enrollees in [Medicare] Part C are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction [of the disproportionate share (DSH) adjustment], or whether, if not regarded as 'entitled to benefits under Part A,' they should instead be included in the Medicaid fraction of the DSH adjustment."[1]

Background on Medicare Part C

Medicare Health Maintenance Organizations and the Medicare Advantage Program[2, 3]

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health

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[2] *See http://www.medicare.gov/glossary/m.html.* (A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide beneficiaries with all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If a beneficiary is enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.) (last visited August 4, 2014).

[3] See *http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/* (The [Medicare + Choice (M+C)] program in Part C of Medicare was renamed the Medicare Advantage (MA) Program under the Medicare Prescription Drug, Improvement, and Modernization Act

maintenance organizations (HMOs) and competitive medical plans (CMPs) is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days. In the September 4, 1990 Federal Register, the Secretary[4] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including

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[4] of Health and Human Services.

> HMO days in the SSI/Medicare percentage [of the DSH adjustment].[5]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[6]

With the creation of Medicare Part C in 1997,[7] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the intermediaries to calculate DSH payments for the FY 2001-2004.[8]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the Federal fiscal year (FFY) 2004 Inpatient Prospective Payment System (IPPS) proposed rules were published in the May 9, 2003 Federal Register. In that notice the Secretary stated that:

> . . . an individual is eligible to elect an M+C plan if he or she is entitled to Medicare Part A and enrolled in Part B. However, once a beneficiary has

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[5] 55 Fed. Reg. 35,990, 39,994 (September 4, 1990).

[6] *Id.*

[7] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.—An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ."

[8] 69 Fed. Reg. 48,918, 49,099 (August 11, 2004).

> elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.*[9]

The Secretary purportedly changed her position in the FFY 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R] § 412.106(b)(2)(i) to include the days associated with [M+C] beneficiaries in the Medicare fraction of the DSH calculation."[10] In response to a comment regarding this change, the Secretary explained that:

> . . . *we do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient

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[9] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003) (emphasis added)

[10] 69 Fed. Reg. 49,098, 49,099 (August 11, 2004).

> days will be included in the numerator of the Medicare fraction.[11]

Although change in policy regarding 42 C.F.R § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until the FFY 2008 final rule was published in the August 22, 2007 Federal Register.[12] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule, published in the August 11, 2004 Federal Register. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004. In this Federal Register notice the Secretary stated that:

> In the FY 2005 IPPS final rule (69 FR 49099), we discussed in the preamble our policy change to reflect the inclusion of the days associated with Medicare+ Choice (now Medicare Advantage) beneficiaries under Medicare Part C in the Medicare fraction of the DSH calculation. In that rule, we indicated that we were revising the regulation text at [42 C.F.R.] § 412.106(b)(2)(i) to incorporate this policy. However, we inadvertently did not make a change in the regulation text to conform to the preamble language. We also inadvertently did not propose to change § 412.106(b)(2)(iii) in the FY 2005 final rule, although we intended to do so. Section 412.106(b)(2)(i) of the regulations discusses the numerator of the Medicare

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[11] *Id. (emphasis added)*

[12] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).

fraction of the Medicare disproportionate patient percentage (DPP) calculation while § 412.106(b)(2)(iii) of the regulations discusses the denominator of the Medicare fraction of the Medicare DPP. We intended to amend the regulation text with respect to both the numerator and the denominator of the Medicare fraction of the Medicare DPP. Therefore, in this final rule with comment period, we are making this technical correction to § 412.106(b)(2)(i) and to § 412.106(b)(2)(iii) to make them consistent with the preamble language of the FY 2005 IPPS final rule and to effectuate the policy iterated in that rule.

With respect to the technical correction that we are making to § 412.106(b)(2)(iii), we note that we ordinarily publish a notice of proposed rulemaking in the Federal Register to provide for a period for public comment before a provision such as this would take effect. However, we can waive this procedure if an agency finds good cause that a notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the notice issued. We find it unnecessary to undertake notice and comment rulemaking in this instance for the additional change to § 412.106(b)(2)(iii) because this notice merely provides technical corrections to the regulations and does not make any substantive changes to the regulations or our existing policy. Therefore, under 5 U.S.C. 533(b)(B), for good cause, we waive notice and comment procedures.[13]

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[13] *Id.*

Federal Court Decisions in *Allina Health Services v. Sebelius (Allina)*[14]

In the District Court decision in *Allina* the Court concluded that the Secretary's interpretation of the fractions used in the DSH calculation and not added to the Code of Federal Regulations until the summer of 2007 (FFY 2008) were not a logical outgrowth of the notice of proposed rulemaking in 2003. In fact, the Secretary's actions were a 180-degree shift in position and a reasonable person would not have understood that such a conclusion would be reached. The Court found that the 2003 notice of proposed rulemaking did not provide adequate notice of the interpretation of the DSH fraction adopted by the Secretary in 2004 in violation of the Administrative Procedures Act and Medicare Act. The Court determined that vacatur was appropriate because the Secretary did not validly change her interpretation of the DSH calculation prior to 2007 and ordered recalculation without using the interpretation in the 2004 rule.[15]

On appeal, the D.C. Circuit Court[16] affirmed the vacatur, but determined that remanding for payment without using the 2004 Final Rule was not correct. Rather than telling the Secretary how to calculate the hospitals' reimbursement, the case should have been remanded with the error identified. The Circuit Court limited its ruling to finding that the change to the policy was not a logical outgrowth of the proposed rule. The Secretary had argued that she might obtain the same

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[14] 904 F. Supp. 2d 75 (D.D.C. 2012)

[15] *Id.* at 95.

[16] 746 F.3d 1102 (D.C. Cir. 2014).

result [application of the invalid rule] through adjudication and since that issue was not before the court, the district court erred in ordering recalculation.[17]

Providers' Requests for EJR

The Providers explain that they were all participants in the *Allina* cases[18] discussed above in which the Federal courts vacated the Secretary's 2004 change to the treatment of Medicare Part C days in the DSH calculation. The Providers were all reimbursed by applying the regulation that was invalidated by the Courts. They are seeking an expeditious ruling on whether the rule remains valid and applicable after the *Allina* decisions or whether the Secretary's actions constitutes unlawful nonacquiecence of binding D.C. Circuit law and a violation of statutory procedural requirements. The Providers do not believe the Board has the authority to grant the relief sought.

The Providers note that in 2013 the Secretary recalculated the Part A/SSI fractions for FFYs 2010 and 2011 for all hospitals nationwide to include Part C days. However, in accordance with the Court's vacatur of the 2004 rule, the Secretary calculated revised fractions for the Providers that excluded the Part C days consistent with the pre-2004 policy. In addition, while *Allina* was pending in the courts, the Secretary engaged in rule making by issuing a new notice and comment stating

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[17] *Id.* at 1111.

[18] Generally, the *Allina* cases heard in the District of Columbia district and circuit courts involve the FFYs 2007 and 2008. The current cases involve later FFYs.

that the agency proposed to readopt the policy of counting Part C days in the Medicare fraction.[19]

Although the time for the Secretary to file a petition for *certiorari* from the *Allina* decision expired June 30, 2014, the Secretary has not issued a notice acquiescing in the D.C. Circuit Court's vacatur. In mid-June of 2014, the agency published the Part A/SSI fractions for 2012, including Part C days for all hospitals. The Providers notified the Secretary of their view that the inclusion of Part C days in the Medicare fraction violated the D.C. Circuit court's decision and new fractions should be calculated. The Providers indicate the Secretary responded that new fractions would not be calculated. The Providers contend that the vacatur restores the previously governing policy until there is a change through valid rulemaking.

Decision of the Board

The Board finds that EJR is appropriate for the issue under dispute in these cases. 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit expedited judicial review where the Board determines that has jurisdiction over the appeal but it does not have the authority to decide a question of law, regulation or CMS ruling. In this case, the Providers are challenging the whether "enrollees in [Medicare] Part C are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction [of the DSH adjustment], or whether, if not regarded as 'entitled to bene-

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[19] *See* 78 Fed. Reg. 50,496, 50,615 (August 19, 2013).

fits under Part A,' they should instead be included in the Medicaid fraction of the DSH adjustment."[20]

The Board has reviewed the submissions of the Providers pertaining to the request for hearing and expedited judicial review. The Intermediary did not oppose the request for EJR. The documentation shows that the estimated amount in controversy exceeds $50,000 for a group appeal and the appeals were timely filed. In addition, the Providers protested the issue on their as-filed cost reports as required by 42 C.F.R. § 405.1835(a)(1)(ii).

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' unopposed assertions regarding the Medicare Part C issue and the Secretary's actions subsequent to the decision in *Allina*, there are no findings of fact for resolution by the Board;

3) it is bound by the regulation; and

4) it is without the authority to decide the legal question of whether the regulation regarding the treatment of Medicare Part C days is valid and whether the Secretary's actions subsequent to the decision in *Allina* are legal.

Accordingly, the Board finds that the Medicare Part C days issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provid-

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[20] Providers' Requests for EJR at 4.

er's request for expedited judicial review for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Board Members Participating

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:
/s/ MICHAEL W. HARTY
MICHAEL W. HARTY
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1), Schedules of Providers

cc: Kyle Browning, NGS (w/Schedules of Providers)
Danene Hartley, NGS (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

Schedule of Providers in Group

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Group Name: Akin Group 2012 Post-Allina Decision Medicare Part C Days Group — Page No. 1 of 2

Representative: Akin Gump Strauss Hauer & Feld LLP — Date Prepared: 7/14/2014

Case No: 14-3726G

Issue: Whether Medicare Part C days were properly treated in the calculation of the Medicare DSH payment.

Lead Intermediary: National Government Services

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	10-0138	Tampa General Hospital (Tampa, Hillsborough, FL)	First Coast Service Options - FL	9/30/2012	3/1/2014*	7/1/2014	122	N/A	$1,543,559	Direct Add	7/1/2014
2	33-0059	MontiFiore Medical Center (Bronx, Bronx, NY)	National Government Services	12/31/2012	6/5/2014*	7/1/2014	28	N/A	$15,080,765	Direct Add	7/1/2014
3	10-0254	Mount Sinai Medical Center (Miami Beach, Dade, FL)	First Coast Service Options - FL	12/31/2012	5/28/2014*	7/8/2014	41	N/A	$4,717,292	Direct Add	7/8/2014
4	33-0085	New York Hospital Queens (Flushing, Queens, NY)	National Government Services	12/31/2012	6/5/2014*	7/8/2014	33	N/A	$7,302,982	Direct Add	7/8/2014
5	33-0226	New York Methodist Hospital (Brooklyn, Kings, NY)	National Government Services	12/31/2012	6/5/2014*	7/8/2014	33	N/A	$7,353,087	Direct Add	7/8/2014

*There is no final determination. This date is one year from the date of cost report receipt, which is when the 180 day appeal clock starts to run.

Schedule of Providers in Group

Group Name: Akin Gump 2012 Post-Allina Decision Medicare Part C Days Group — Page No. 2 of 2

Representative: Akin Gump Strauss Hauer & Feld LLP — Date Prepared: 7/11/2014

Case No: 14-3726G

Issue: Whether Medicare Part C days were properly counted in the calculation of the Medicare DSH payment.

Lead Intermediary: National Government Services

Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
6 33-0101	New York Presbyterian Hospital (New York, New York, NY)	National Government Services	12/31/2012	6/3/2014[A]	7/14/2014	41	N/A	$8,537,575	Direct Add	7/14/2014

Total Amount of Reimbursement: $45,115,080

[A] There is no final determination. This date is one year from the date of cost report receipt, which is when the 180 day appeal clock starts to run.

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Schedule of Providers in Group

Group Name: Allina Health 2012 Post-Allina Decision Medicare Part C Days Group

Page No. 1 of 1

Representative: Alvin Gunn Stinson Henry & Reid LLP

Date Prepared 7/25/2014

Case No: Not Yet Assigned 14-3813GC

Issue: Whether Medicare Part C days were properly treated in the calculation of the Medicare DSH payment.

Lead Intermediary: National Government Services

Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Req Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Clm No.	G Date Add/ Transfer Filed
1 24-0058	United Hospital (St. Paul, Ramsey, MN)	National Government Services	12/31/2012	6/5/2014*	7/25/2014	52	N/A	$423,946	Direct Add	7/25/2014
2 24-0087	Abbott Northwestern Hospital (Minneapolis, Hennepin, MN)	National Government Services	12/31/2012	5/24/2014*	7/25/2014	62	N/A	$1,948,054	Direct Add	7/25/2014
3 24-0152	Unity Hospital (Fridley, Anoka, MN)	National Government Services	12/31/2012	5/24/2014*	7/25/2014	62	N/A	$613,341	Direct Add	7/25/2014

Total Amount of Reimbursement $3,374,341

*There is no final determination. This date is one year from the date of cost report receipt, which is when the 180 day appeal clock starts to run.

APPENDIX F

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 16-5255

ALLINA HEALTH SERVICES, DOING BUSINESS AS UNITED HOSPITAL, DOING BUSINESS AS UNITY HOSPITAL, DOING BUSINESS AS ABBOTT NORTHWESTERN HOSPITAL, ET AL., APPELLANTS

v.

ERIC D. HARGAN, ACTING SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, APPELLEE

Filed: Nov. 29, 2017

ORDER

Before: HENDERSON, KAVANAUGH, and MILLETT, *Circuit Judges.*

Upon consideration of appellee's petition for panel rehearing filed on October 4, 2017, and the response thereto, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY: /s/
Ken R. Meadows
Deputy Clerk

APPENDIX G

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 16-5255

ALLINA HEALTH SERVICES, DOING BUSINESS AS UNITED HOSPITAL, DOING BUSINESS AS UNITY HOSPITAL, DOING BUSINESS AS ABBOTT NORTHWESTERN HOSPITAL, ET AL., APPELLANTS

v.

ERIC D. HARGAN, ACTING SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, APPELLEE

Filed: Nov. 29, 2017

ORDER

Before: GARLAND, *Chief Judge*; HENDERSON, ROGERS, TATEL, GRIFFITH, KAVANAUGH, SRINIVASAN, MILLETT, PILLARD, and WILKINS, *Circuit Judges*.

Upon consideration of appellee's petition for rehearing en banc, the response thereto, and the absence of a request by any member of the court for a vote, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY: /s/
Ken R. Meadows
Deputy Clerk

APPENDIX H

1. 5 U.S.C. 551 provides in pertinent part:

Definitions

For the purposes of this subchapter—

* * * * *

(4) "rule" means the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency and includes the approval or prescription for the future of rates, wages, corporate or financial structures or reorganizations thereof, prices, facilities, appliances, services or allowances therefor or of valuations, costs, or accounting, or practices bearing on any of the foregoing;

(5) "rule making" means agency process for formulating, amending, or repealing a rule;

(6) "order" means the whole or a part of a final disposition, whether affirmative, negative, injunctive, or declaratory in form, of an agency in a matter other than rule making but including licensing;

(7) "adjudication" means agency process for the formulation of an order;

* * * * *

2. 5 U.S.C. 553 provides:

Rule making

(a) This section applies, according to the provisions thereof, except to the extent that there is involved—

(1) a military or foreign affairs function of the United States; or

(2) a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.

(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include—

(1) a statement of the time, place, and nature of public rule making proceedings;

(2) reference to the legal authority under which the rule is proposed; and

(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this subsection does not apply—

(A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or

(B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and

public procedure thereon are impracticable, unnecessary, or contrary to the public interest.

(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

(d) The required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except—

(1) a substantive rule which grants or recognizes an exemption or relieves a restriction;

(2) interpretative rules and statements of policy; or

(3) as otherwise provided by the agency for good cause found and published with the rule.

(e) Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.

3. 42 U.S.C. 1395w-21 (2012) provides in pertinent part:

Eligibility, election, and enrollment

(a) Choice of medicare benefits through Medicare+Choice plans

(1) In general

Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) under this subchapter—

(A) through the original medicare fee-for-service program under parts A and B of this subchapter, or

(B) through enrollment in a Medicare+Choice plan under this part,

and may elect qualified prescription drug coverage in accordance with section 1395w-101 of this title.

(2) Types of Medicare+Choice plans that may be available

A Medicare+Choice plan may be any of the following types of plans of health insurance:

(A) Coordinated care plans (including regional plans)

(i) In general

Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without point of service options), plans offered by

provider-sponsored organizations (as defined in section 1395w–25(d) of this title), and regional or local preferred provider organization plans (including MA regional plans).

(ii) Specialized MA plans for special needs individuals

Specialized MA plans for special needs individuals (as defined in section 1395w-28(b)(6) of this title) may be any type of coordinated care plan.

(B) Combination of MSA plan and contributions to Medicare+Choice MSA

An MSA plan, as defined in section 1395w-28(b)(3) of this title, and a contribution into a Medicare+Choice medical savings account (MSA).

(C) Private fee-for-service plans

A Medicare+Choice private fee-for-service plan, as defined in section 1395w-28(b)(2) of this title.

(3) Medicare+Choice eligible individual

(A) In general

In this subchapter, subject to subparagraph (B), the term "Medicare+Choice eligible individual" means an individual who is entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter.

(B) Special rule for end-stage renal disease

Such term shall not include an individual medically determined to have end-stage renal disease, except that—

(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan; and

(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in subsection (e)(4)(A) of this section, then the individual will be treated as a "Medicare+Choice eligible individual" for purposes of electing to continue enrollment in another Medicare+Choice plan.

* * * * *

4. 42 U.S.C. 1395hh (1982) provides:

Regulations

The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

5. 42 U.S.C. 1395hh (Supp. IV 1986) provides:

Regulations

(a) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

(b)(1) Except as provided in paragraph (2), before issuing in final form any regulation under subsection (a) of this section, the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon.

(2) Paragraph (1) shall not apply where—

(A) a statute specifically permits a regulation to be issued in interim final form or otherwise with a shorter period for public comment,

(B) a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained, or

(C) subsection (b) of section 553 of title 5 does not apply pursuant to subparagraph (B) of such subsection.

6. 42 U.S.C. 1395hh (1988) provides:

Regulations

(a) Authority to prescribe regulations; ineffectiveness of substantive rules not promulgated by regulation

(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

(2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

(b) Notice of proposed regulations; public comment

(1) Except as provided in paragraph (2), before issuing in final form any regulation under subsection (a) of this section, the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon.

(2) Paragraph (1) shall not apply where—

(A) a statute specifically permits a regulation to be issued in interim final form or otherwise with a shorter period for public comment,

(B) a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained, or

(C) subsection (b) of section 553 of title 5 does not apply pursuant to subparagraph (B) of such subsection.

(c) **Publication of certain rules; public inspection; changes in data collection and retrieval**

(1) The Secretary shall publish in the Federal Register, not less frequently than every 3 months, a list of all manual instructions, interpretative rules, statements of policy, and guidelines of general applicability which—

(A) are promulgated to carry out this subchapter, but

(B) are not published pursuant to subsection (a)(1) of this section and have not been previously published in a list under this subsection.

(2) Effective June 1, 1988, each fiscal intermediary and carrier administering claims for extended care, post-hospital extended care, home health care, and durable medical equipment benefits under this subchapter shall make available to the public all interpretative materials, guidelines, and clarifications of policies which relate to payments for such benefits.

(3) The Secretary shall to the extent feasible make such changes in automated data collection and retrieval by the Secretary and fiscal intermediaries with agreements under section 1395h of this title as are necessary to make easily accessible for the Secretary and other

appropriate parties a data base which fairly and accurately reflects the provision of extended care, post-hospital extended care and home health care benefits pursuant to this subchapter, including such categories as benefit denials, results of appeals, and other relevant factors, and selectable by such categories and by fiscal intermediary, service provider, and region.

7. 42 U.S.C. 1395hh provides:

Regulations

(a) Authority to prescribe regulations; ineffectiveness of substantive rules not promulgated by regulation

(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

(2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publi-

cation of a proposed regulation or an interim final regulation.

(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the

applicable regular timeline under this paragraph and that provides an explanation for such failures.

(4) If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.

(b) Notice of proposed regulations; public comment

(1) Except as provided in paragraph (2), before issuing in final form any regulation under subsection (a) of this section, the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon.

(2) Paragraph (1) shall not apply where—

(A) a statute specifically permits a regulation to be issued in interim final form or otherwise with a shorter period for public comment,

(B) a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained, or

(C) subsection (b) of section 553 of title 5 does not apply pursuant to subparagraph (B) of such subsection.

(c) Publication of certain rules; public inspection; changes in data collection and retrieval

(1) The Secretary shall publish in the Federal Register, not less frequently than every 3 months, a list of all manual instructions, interpretative rules, statements of policy, and guidelines of general applicability which—

(A) are promulgated to carry out this subchapter, but

(B) are not published pursuant to subsection (a)(1) of this section and have not been previously published in a list under this subsection.

(2) Effective June 1, 1988, each fiscal intermediary and carrier administering claims for extended care, post-hospital extended care, home health care, and durable medical equipment benefits under this subchapter shall make available to the public all interpretative materials, guidelines, and clarifications of policies which relate to payments for such benefits.

(3) The Secretary shall to the extent feasible make such changes in automated data collection and retrieval by the Secretary and fiscal intermediaries with agreements under section 1395h of this title as are necessary to make easily accessible for the Secretary and other appropriate parties a data base which fairly and accurately reflects the provision of extended care, post-hospital extended care and home health care benefits pursuant to this subchapter, including such categories as benefit denials, results of appeals, and other relevant factors, and selectable by such categories and by fiscal intermediary, service provider, and region.

(e)[1] Retroactivity of substantive changes; reliance upon written guidance

(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this subchapter shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

(i) such retroactive application is necessary to comply with statutory requirements; or

(ii) failure to apply the change retroactively would be contrary to the public interest.

(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

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[1] So in original. No subsec. (d) has been enacted.

(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.

(2)(A) If—

(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1395zz(g) of this title) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any penalty or interest under this subchapter or the provisions of subchapter XI of this chapter insofar as they relate to this subchapter (including interest under a repayment plan under section 1395ddd of this title or otherwise) relating to the provision of such items or service or such claim if the provider of services or supplier reasonably relied on such guidance.

(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.

(f) Report on areas of inconsistency or conflict

(1) Not later than 2 years after December 8, 2003, and every 3 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this subchapter and areas of inconsistency or conflict among the various provisions under law and regulation.

(2) In preparing a report under paragraph (1), the Secretary shall collect—

(A) Information from individuals entitled to benefits under part A or enrolled under part B of this subchapter, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman with respect to such areas of inconsistency and conflict; and

(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.

8. 42 U.S.C. 1395ww provides in pertinent part:

Payments to hospitals for inpatient hospital services

* * * * *

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographical Classification Review Board

* * * * *

(5)(A)(i)

* * * * *

(F)(i) Subject to subsection (r), for discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

(II) is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this subchapter or State plans approved under subchapter XIX of this chapter), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

* * * * *

(v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—

(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

(II) 30 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),

(III) 40 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in an urban area and has less than 100 beds, or

(IV) 45 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and is not described in subclause (II).

A hospital located in a rural area and with 500 or more beds also "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

* * * * *

9. 42 C.F.R. 412.106 (2003) provides in pertinent part:

Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(b) *Determination of a hospital's disproportionate patient percentage.* (1) *General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—

(i) Determines the number of patient days that—

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;

(ii) Adds the results for the whole period; and

(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of patient days that—

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A.

(3) *First computation: Cost reporting period.* If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

(iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

(5) *Disproportionate patient percentage.* The intermediary adds the results of the first computation made under either paragraph (b)(2) or (b)(3) of this section and the second computation made under paragraph (b)(4) of this section and expresses that sum as a percentage. This is the hospital's disproportionate patient percentage, and is used in paragraph (c) of this section.

* * * * *

APPENDIX I

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No.: 10-1463 (RMC)

ALLINA HEALTH SERVICES, ET AL., PLAINTIFFS

v.

SYLVIA M. BURWELL, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEFENDANT

DECLARATION OF ING JYE CHENG

I, Ing Jye Cheng, hereby make the following declaration:

1. I am the Director of the Division of Acute Care, Hospital and Ambulatory Care Group, Center for Medicare, Centers for Medicare & Medicaid Services ("CMS"), U.S. Department of Health and Human Services ("HHS"). I have served in this position since June 2014. I had previously served as the Deputy Director of the Division of Acute Care from March 2009 through June 2014.

2. The Center for Medicare develops payment rules and decisions, undertakes benefit category determinations, and formulates Medicare policy for the development and maintenance of new and revised codes. Within the Center for Medicare, the Hospital and Ambulatory Policy Group is responsible for developing and refining acute care hospital payment systems, as well as most outpatient and practitioner payment systems. This group contains four divisions including the Divi-

sion of Acute Care, which defines the scope of payments for Medicare benefits for services provided by acute care hospitals to inpatients, and develops, updates, and evaluates the hospital inpatient prospective payment systems ("IPPS") for payments to hospitals for inpatient services and associated capital costs.

3. I make this declaration based upon my personal knowledge and information available to me in my official capacity.

4. I am familiar with the subject matter of the above-captioned lawsuit, which involved a challenge to a regulation CMS adopted on August 11, 2004, governing the calculation of disproportionate share hospital ("DSH") payments. *See* 69 Fed. Reg. 48,916, 49,099 (Aug. 11, 2004). The rule required that patients enrolled in a Medicare part C plan (Medicare Advantage) would be counted as "entitled to benefits under part A" under 42 U.S.C. § 1395ww(d)(5)(F)(iv)(I) and therefore included in the numerator of the Medicare SSI fraction. Prior to the regulation adopted on August 11, 2004, CMS had not previously addressed that question by rulemaking.

5. On November 12, 2012, this Court vacated that rule, and that decision was upheld by the Court of Appeals on April 1, 2014. CMS understands that the vacated rule has no legal effect and cannot be relied on for any purpose. Accordingly, CMS has stopped relying on the vacated rule for any purpose, and it is my understanding that CMS has verbally instructed its contractors to stop relying on the vacated rule.

6. Because of the vacatur of the rule, there is now no regulation addressing the question of whether patients enrolled in Medicare part C should be considered "entitled to benefits under part A" for purposes of applying 42 U.S.C. § 1395ww(d)(5)(F)(iv) to time periods before October 1, 2014. In the absence of a regulation interpreting the statute, CMS nevertheless must apply some interpretation of the statute in order to make DSH payments to hospitals.

7. One step in the calculation of a hospital's DSH payments for a given year is the computation of a provider's SSI fraction. This requires the matching of individual Medicare billing records (maintained by CMS) to individual SSI records (maintained by the Social Security Administration). CMS makes these SSI fractions available to Medicare Administrative Contractors ("MAC"); MACs then calculate a provider's Medicaid fraction based on data submitted by the provider and determine the disproportionate patient percentage. 42 C.F.R. § 412.106(b)(4)-(5). As part of the process for making SSI fractions available to MACs, CMS posts SSI fractions on this website. Posted SSI fractions are not final payment determinations appealable under 42 U.S.C. § 1395oo. Plaintiffs' posted 2012 SSI fractions were not calculated in reliance on the vacated rule.

8. This case has been remanded back to the Secretary for a decision regarding the calculation of plaintiffs' DSH payments that does not rely on the vacated regulation. Plaintiffs will, accordingly, receive a new decision regarding those DSH payments. If that decision is adverse to the plaintiffs, they will be able to appeal as provided for in 42 U.S.C. § 1395oo. Pending a final adjudicatory decision of the Secretary address-

ing the question of whether the days of patients enrolled in Medicare part C should be treated as "entitled to benefits under part A" when applying 42 U.S.C. § 1395ww(d)(5)(F)(iv), CMS is calculating DSH payments according to what it believes to be the most appropriate interpretation of the statute in the absence of a binding regulation on that question.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. 28 U.S.C. § 1746. Executed this 4 day of August 2014.

/s/ ING JYE CHENG
Name